COMMITTEE REPORT(S)

(3)

COUNCIL OF THE DISTRICT OF COLUMBIA
441 Fourth Street, N.W.
Washington, D.C. 20001

Report

TO: ALL COUNCILMEMBERS

FROM: HAROLD BRAZIL, CHAIRMAN
COMMITTEE ON CONSUMER & REGULATORY AFFAIRS

DATE: February 24, 1998

RE: **Bill 12-152, the "Definition of Optometry Amendment Act of 1997"**

The Committee on Consumer & Regulatory Affairs reports favorably on Bill 12-152, the "Definition of Optometry Amendment Act of 1997", and recommends its enactment by the Council of the District of Columbia.

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I. PURPOSE

The purpose of Bill 12-152 is to amend the definition of optometry in the District of Columbia Health Occupations Revision Act of 1985 to allow doctors of optometry the ability to prescribe certain therapeutic medicines.

II. LEGISLATIVE HISTORY

March 13, 1997	Bill 12-152, the "Definition of Optometry Amendment Act of 1997" was co-introduced by Councilmember Evans and Chairman Cropp.
May 28, 1997	The Committee on Consumer & Regulatory Affairs held a Public Roundtable to receive testimony on Bill 12-152.
February 24, 1998	The Committee on Consumer & Regulatory Affairs held a meeting to mark-up and vote on Bill 12-152.

III. BACKGROUND & ISSUES

Optometrists in 50 states, the Indian Health Service of the United States Public Health Service, the Veteran's Health Administration, and the military services are now providing comprehensive primary eye care which includes the use of therapeutic pharmaceutical agents (TPA's) to treat eye diseases. The fact that malpractice rates have not increased in these therapeutic states is an indication of the safe and effective use of ocular therapeutic pharmaceuticals by optometrists.

Bill 12-152 incudes language specifying that only optometrists who demonstrate the necessary education and training will be authorized to use TPA's to treat eye disease.

IV. SUMMARY OF PUBLIC TESTIMONY

The Committee convened a public roundtable on May 28, 1997, to receive public comment on Bill 12-152. There were numerous public witnesses present and Dr. Derrick Artis, the Chairman of the D.C. Board of Optometry, represented the Executive Branch. The summary of testimony is as follows:

Dr. Derrick Artis, Chairman of the D.C. Board of Optometry--Dr. Artis testified on behalf of the D.C. Board of Optometry in full support of Bill 12-152. Dr. Artis stated that the board is a government agency established to regulate the practice of optometry in the District of Columbia, and as a board member, he took an oath to protect the visual welfare of the citizens. However, under current law, the citizens of the District are unable to receive the optometric care commensurate with the either the surrounding jurisdictions nor 49 other states.

Additionally, Dr. Artis testified that the number of optometrists applying to practice in D.C. has decreased dramatically because of the District's restrictive optometry laws. He stated that Bill 12-152 will help attract some of those doctors to the District and this will help improve not only the access but also the quality of eyecare District residents receive.

Dr. Michael Rosenblatt, Optometric Society of D.C.--Dr. Michael Rosenblatt testified in support of Bill 12-152 on behalf of the Optometric Society of D.C. Dr. Rosenblatt testified that he is a doctor of optometry with two offices in the District of Columbia and that he is also licensed in Virginia, where he is allowed to prescribe therapeutic agents.

Mr. Rosenblatt stated that in the past the District was recognized and respected throughout the country for its definition of optometric practice, but unfortunately, this is no longer true because 49 other states have passed bill such as 12-152 years ago. He also testified that his organization has been trying for 4 years to get a hearing on this bill to no avail.

Dr. Stephen L. Schneid--Dr. Schneid testified in support of Bill 12-152 as a way to redefine the scope of care of qualified optometrists in the District. Dr. Schneid testified that he operates 3 offices in the metro are; one in Arlington, VA, one in Takoma Park, MD, and one in the District and that he personally finds it time consuming, costly and inconvenient to ask his District patients to travel across the bridge for therapeutic eyecare.

Dr. Bradford Dunn--Dr. Dunn testified in full support of Bill 12-152. Dr. Dunn stated that he is the lead optometrist at Kaiser Permanente's West End Medical Center on Pennsylvania Avenue and was employed for ten years in the practice of optometry as an officer with the US Air Force. He stated that the military recognized long ago the benefits of allowing optometrists the right to prescribe TPA's and that the Air Force has followed this model for over 15 years.

Dr. James D. Colgain--Dr. Colgain testified in support of Bill 12-152. Dr. Colgain is the Chief of Optometry for Kaiser Permanente and is responsible for the recruitment of optometrists to the region. Dr. Colgain stated in his testimony that it is always more difficult to recruit optometrists for the Kaiser Centers in the District because the District is the only jurisdiction that does not allow optometrists to use the full skills for which they are trained. Given a choice, the optometrists always preferred to work in a site were the state laws allowed them to use to treat their patients with therapeutic medications.

Dr. John Minardi--Dr. Minardi testified in support of Bill 12-152. Dr. Minardi stated that currently an optometrists in the District who examines a patient with an eye infection or minor trauma must diagnose the problem and then refer that patient to an MD for treatment. He testified that this results in a duplication of diagnostic procedures, patient delay in receiving the necessary treatment, discontinuity of care, additional time lost from work and significant additional fees to patients.

Dr. Jay Helfgot--Dr. Helfgot is the Chairman of Ophthalmology at the Washington Hospital Center. Dr. Helfgot believes that Bill 12-152 is good in that the definition of optometric practice should be considered by the

District but he had several concerns about this bill. His concerns were: that surgery be defined unequivocally; that the experience of non-commercial staff model practices be reviewed; that the Licensing Authority in DC be restructured to cover all healing arts; that the purpose of the legislation be defined; and that the MD's and the OD's work together to work out the healing arts.

Dr. Howard Cupples--Dr. Cupples is a Professor and Chairman of the Department of Ophthalmology at Georgetown University Medical School and testified against Bill 12-152. Dr. Cupples felt that the training and education received by ophthalmologists make them by far more qualified than optometrists to treat eye patients.

Dr. Samuel Stopak--Dr. Stopak testified that the Medical Society of DC and the Washington Ophthalmology Society agree with the basic concept of the bill: there needs to be clear delineation of the practice scope of optometrists and ophthalmologists. However, he expressed critical areas of concern with the legislation. Most importantly, the legislation is too vague and does not specify necessary distinctions about the practice of optometry.

For instance, with respect to surgerical applications, the bill, while mentioning some limitations, implies that laser surgery is not invasive surgery and therefore may be conducted by an optometrist. Presently 47 states prohibit optometric surgery, with 36 of those states specifically prohibiting optometric laser surgery. We believe that language should be added to Bill 12-152 defining all laser procedures as surgery and eliminating the possibility of optometrists performing any surgery.

V. *SECTION-BY-SECTION ANALYSIS*

Section 2

Section 2 amends the District of Columbia Health Occupations Act of 1997 is amended to allow optometrists the ability to prescribe therapeutic and diagnostic agents if certified by the Board of Optometry.

This section also directs the Mayor to promulgate regulations governing the practice of Optometry.

Section 3

Section 3 is the standard effective date clause.

VI. FISCAL IMPACT

The Committee adopts the attached fiscal impact statement prepared by the Office of the Chief Financial Officer which states that this bill will have no negative fiscal impact on the District of Columbia Budget and Financial Plan.

VII. IMPACT ON EXISTING LAW

Bill 12-152 would expand definition of optometry to allow optometrists who demonstrate the necessary education and training will be authorized to use TPA's to treat eye disease.

VIII. COMMITTEE ACTION

The Committee on Consumer and Regulatory Affairs met on February 24,1998 to consider Bill 12-152, the "Definition of Optometry Amendment Act of 1997" along with the Committee Report for discussion and approval.

Councilmember Allen asked was this the bill that allowed optometrists to prescribe medications. Councilmember Brazil stated that yes it is but it will be very limited. Chairman Brazil stated that the optometrists and the Medical Society are working on compromise medicines now but gave their permission for us to go ahead and markup the bill so that the full Council may consider it. Additionally, Chairman Brazil stated that all 50 states have similar legislation.

Councilmember Allen replied that she did not care what the other states were doing because she did not approve of this legislation and was going to vote against

it.

The Committee vote was as follows:

Chairperson Brazil	AYE
Councilmember Allen	NO
Councilmember Catania	AYE
Councilmember Evans	ABSENT
Councilmember Smith	ABSENT

IX. ATTACHMENTS

a. Committee Print of Bill 12-152, the "Definition of Optometry Amendment Act of 1997"

b. Bill 12-152, the "Definition of Optometry Amendment Act of 1997" as introduced.

c. Testimony of Dr. Derrick Artis.

d. Testimony of Dr. Michael Rosenblatt.

e. Testimony of Dr. Steven L. Schneid.

f. Testimony of Dr. Bradford Dunn.

g. Testimony of Dr. James D. Colgain..

h. Testimony of Dr. John Minardi.

i. Testimony of Dr. Jay Helfgott.

j. Testimony of Dr. Howard Cupples.

k. Testimony of Dr. Samuel Stopak.

l. Letters submitted for the record.

m. Fiscal impact statement.

Committee Print
Committee on Consumer & Regulatory
Affairs
February 24, 1998

A BILL

12-152

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the definition of optometry in the District of Columbia Health Occupations Revision Act of 1985 to allow doctors of optometry to prescribe certain therapeutic medicines.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Definition of Optometry Amendment Act of 1997".

Sec. 2. The District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Code § 2-3301.1 *et seq.*) is amended as follows:

(a) Section 102 (D.C. Code § 2-3301.2) is amended to read as follows:

"(10) (A) "Practice of optometry" means the application of the scientific principles of optometry in the examination of the human eye, its adnexa, appendages or visual system, with or without the use of diagnostic pharmaceutical agents to prevent, diagnose, or treat defects of abnormal conditions; the prescription or use of lenses, prisms, orthoptics, vision training/therapy, low vision rehabilitation, therapeutic pharmaceutical agents or prosthetic devices; or the application of any method other than invasive surgery necessary to prevent, diagnose or treat any defects or abnormal conditions of the human eye, its adnexa, appendages, or visual system.

"(B) The Mayor shall issue rules identifying which, and under what circumstances,

diagnostic and therapeutic pharmaceutical agents may be used by optometrists pursuant to this paragraph.

"(C) An individual licensed to practice optometry pursuant to this act may use diagnostic and therapeutic agents only if certified to do so by the Board of Optometry in accordance with the provisions of section 207 of this act.

"(D) Nothing in this paragraph shall be construed to authorize an individual licensed to practice optometry to use surgical lasers; perform any surgery including cataract surgery or cryosurgery; perform radial keratomomy; administer drugs by injection except for injections to counter anaphylactic reaction; or to administer or prescribe any drug for any purpose other than that authorized by this paragraph. For the purpose of the subparagraph, the term surgery shall not include punctal plugs; foreign body removal; epilation; and dilation and irrigation as approved by the Board of Optometry.

"(E) Nothing in this paragraph shall be construed as preventing or restricting the practice, services, or activities of a licensed physician, or as prohibiting an optician from providing eyeglasses or lenses on the prescription of a licensed physician or optometrist, or a dealer from selling eyeglasses or lenses, provided that the optician or dealer does not represent by title or description of services that he or she is an optometrist.

(b) Section 207 (D.C. Code § 203302.7) is amended by adding the following new subsection (g) to read as follows:

"(g) The Board shall grant applications for certification to administer therapeutic pharmaceutical agents to applicants who demonstrate to the satisfaction of the Board that they have:

"(1) Been certified by the Board to use diagnostic pharmaceutical agents:

"(2) Successfully completed a Board-approved course in the use of therapeutic pharmaceutical agents as it relates to the practice of optometry, offered by an accredited institution of higher learning; and

"(3) Passed an examination administered or approved by the Board on the use of therapeutic pharmaceutical agents."

Sec. 3. This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council of the District of Columbia to override the veto), approval by the Financial Responsibility and Management Assistance Authority as provided in section 203(a) of the District of Columbia Financial Responsibility and Management Authority Act of 1995, approved April 17, 1995 (109 Stat. 116; D.C. Code § 47-392.3(c)), and a 60-day period of Congressional review as provided in section 602(c)(2) of the District of Columbia Self-Government and Governmental Reorganization Act, approved December 24, 1973 (87 Stat. 813; D.C. Code §1-233(c)(2)), and publication in the District of Columbia Register.

Councilmember Jack Evans

Councilmember Linda Cropp

A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

Councilmember Jack Evans and Councilmember Linda Cropp introduced the following bill, which was referred to the Committee on _____.

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defects or abnormal conditions of the human eye, its adnexa, appendages, or visual system.

"(B) The Mayor shall issue rules identifying which, and under what circumstances, diagnostic and therapeutic pharmaceutical agents may be used by optometrists pursuant to this paragraph.

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"(D) Nothing in this paragraph shall be construed to authorize an individual licensed to practice optometry to perform invasive surgery, to administer drugs by injection, except for injections to counter anaphylactic reaction, or to administer or prescribe any drug for any purpose other than that authorized by this paragraph.

"(E) Nothing in this paragraph shall be construed as preventing or restricting the practice, services, or activities of a licensed physician, or as prohibiting an optician from providing eyeglasses or lenses on the prescription of a licensed physician or optometrist, or a dealer from selling eyeglasses or lenses, provided that the optician or dealer does not represent by title or description of services that he or she is an optometrist.

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American Optometric Association

DR. DERRICK L. ARTIS
OPTOMETRIST

700 13th Street N.W. • Washington, DC 20005 • (202) 737-2262

May 28, 1997

Good afternoon members of the city council, colleagues, citizens of the District and other interested parties. I am Dr. Derrick Artis, Optometrist. I have been in independent practice in the District of Columbia since 1989. I come before you today as the chairman-elect of the D.C. Board of Optometry and as a proud citizen of Washington, D.C. The D.C. Board of Optometry is in full support of Bill 12-152, the definition of optometry amendment act of 1997.

As you know, the D.C. Board of Optometry is a government agency established to regulate the practice of optometry in the District of Columbia. As board members, we take an oath to protect the visual welfare of the citizens and to assure that all citizens receive the best optometric care available under the law. However, under the current law, the citizens of the District are unable to receive the highest quality optometric care available. In fact, under the current law, the citizens of the District are unable to receive optometric care commensurate with the care provided to citizens in the surrounding jurisdictions and forty-seven other states. Bill 12-152 will simply provide our citizens with the same optometric services provided to citizens in forty-nine other states.

The D.C. Board of Optometry is responsible for licensing new optometrists and securing the optometric manpower needed to serve our citizens. In recent years, the number of optometrists applying to practice in D.C. has decreased dramatically. This has had a negative impact on the number of doctors available to serve our citizens. This decrease in new applicants is due to the fact that new graduates do not want to practice in an area where they can not fully utilize their training. With the passage of Bill 12-152, we will be able to attract the best and brightest young doctors and to provide better accessibility and care to our citizens.

The Board of Optometry is also responsible for taking disciplinary action for any violations of professional standards and regulations committed by optometrists, i.e., all cases of medical malpractice or negligence brought against a licensed optometrist are assessed by the Board. In 1986, legislation was enacted that permits optometrists to administer diagnostic medications to detect eye diseases. This legislation was vigorously opposed by ophthalmologists at that time. They argued that the use of these drugs by optometrists would be a public health risk. Well, in the ten years since the implementation of this law, there have been absolutely no cases of public harm or malpractice brought before the Board concerning the use of these diagnostic medications. The diagnostic

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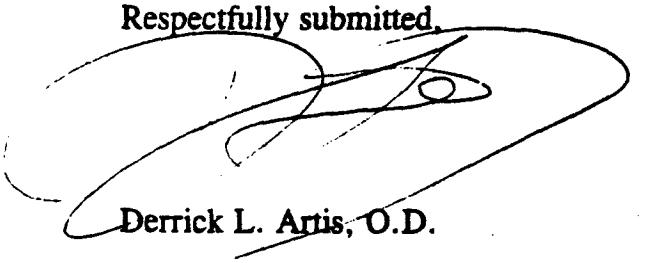
pharmaceutical bill has proven to be a good bill for the citizens of the District. Bill 12-152 will also prove to be good for the citizens of the District.

Finally, I come to you today as a proud citizen of Washington, D.C. I was born and raised in this great city. I left for nine years to pursue my education, but my goal was to return to practice in my hometown. Upon completing my doctorate and clinical training, I was faced with a dilemma. Should I practice in another state where I could fully utilize my training or should I return home to serve my community? I chose to come home and to help improve my city and the status of my chosen profession within my city.

I, like you, have chosen to stay in the District and to work at making our city a better place in which to live. I believe in this city. I believe in our citizens and our elected officials. I believe that this city can be one of the greatest cities on the face of the earth. My contribution to this city as a board member is to protect the visual welfare of our citizens. Your contribution is to protect the overall welfare of the citizens. Bill 12-252 will enable optometrists to provide the best care for our patients. Bill 12-152 will enable you to offer your constituents the same eye care options that citizens in forty-nine other states currently have. I want to sincerely thank you for your time and consideration regarding this matter.

Respectfully submitted,



Derrick L. Artis, O.D.

My name is Dr. Michael Rosenblatt, I am a Doctor of Optometry with two offices in Washington, DC, one at 18th and K Sts. and the other at L'Enfant Plaza. I am also licensed to practice in Virginia where I am certified to prescribe therapeutic medications. I am representing the Optometric Society of the District of Columbia and serve as the current President of the Society.

I am here today with my colleagues to discuss our profession - Optometry. The Optometric Society has submitted written testimony regarding Bill 12-152. We are here today to provide more testimony and answer any questions you may have.

For the past four years, the society and the Board of Optometry have proposed a revision to the definition of optometry.

In the past, the definition of optometry as defined in Washington, DC, was recognized and respected throughout the country. Unfortunately this is no longer true today. I would like to read to you an excerpt from an editorial in the April 1997 issue of **The Journal of the American Optometric Association** titled "One Hundred Years and Counting"

"It is interesting to note that the original optometry laws - which uniformly excluded the use of drugs and surgery from the scope of practice - required 23 years to pass, with the District of Columbia being the last jurisdiction to enact a law. Half a century later, the effort to amend these laws - to permit the use of drugs for diagnosis and treatment - required similar periods. Diagnostic drugs were first authorized (in Rhode Island) in 1971, and by 1989, all states permitted the use of these agents by optometrists (note: Washington, DC was next to last.) Therapeutic drug use was first authorized in 1976 (in West Virginia), and today only <u>two</u> jurisdictions (Massachusetts and the District of Columbia) have yet to enact such amendments..."

With 49 states and Guam already passing such legislation, we can not keep from becoming next-to or even last once again. However, with passage of this bill we can make the Washington, DC definition of optometry one to be respected and recognized throughout the nation.

I have found a statement that I believe best summarizes why my colleagues and myself are here today.

My name is Dr. Michael Rosenblatt, I am a Doctor of Optometry with two offices in Washington, DC, one at 18th and K Sts. and the other at L'Enfant Plaza. I am also licensed to practice in Virginia where I am certified to prescribe therapeutic medications. I am representing the Optometric Society of the District of Columbia and serve as the current President of the Society.

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9004: Access to Treatment for Eye Care by Optometrists

The American Public Health Association,

Noting that more than one-third of all Americans have a disease or physiologic abnormality in one or both eyes;[1] and

Recognizing that only about one-half of the total population in the United States needing treatment for eye disease is receiving it;[2] and

Noting that eye disease and blindness cost the nation an estimated $16 Billion a year;[3] and

Realizing that the eye health problems and vision care demands will increase significantly in the future as the US population ages;[4] and

Observing that optometric services are available in approximately 6,400 communities in the United States and that doctors of optometry are the only primary eye care providers in nearly 4,000 communities, and that the nationwide optometrists outnumber ophthalmologists nearly two to one;[5,6] and

Noting that 60 percent of primary diagnostic eye examinations in the United States[7] are provided by the 25,000 active optometrists;[8] and

Realizing that many people who need medical eye care are already being treated by optometrists in many states;[9] and

Noting that optometric reimbursement rates are typically lower than those of other providers of comprehensive eye care;[10] and

Realizing that many people who want to receive medical eye care are now being treated by optometrists;[10] and

Recognizing that it is prudent public policy to utilize appropriately trained and licensed health professionals at their highest level of skill and training as determined by state licensing laws;[11] and

Noting that Medicare reimburses diagnostic and therapeutic eye care services delivered by optometrists as authorized by state practice acts;[12] and

Noting that 25 states have passed laws and regulations that allow optometrists to use therapeutic pharmaceutical agents[7] after completing appropriate training and testing requirements, and

Observing that the US Department of Veteran Affairs, the US Armed Forces, and the US Public Health Service have regulations or credentialing statements that allow optometrists to utilize therapeutic pharmaceutical agents to benefit of their patients, and noting that this expansion of the clinical privileges of optometrists has increased the availability,,accessability, and cost effectiveness of eye care to the American public through lower fees for services[10] and by a reduction in double visits and hospital emergency room visits; therefore

1. Recommends that legislatures update their state optometric practice acts to allow for optometric use of those diagnostic and therapeutic pharmaceuticals which have been determined by the State Board of Examiners in Optometry as being within the scope of competency of pharmaceutically certified optometrists; and

2. Recommends that dispensing of such pharmaceuticals be regulated by state pharmacy laws.

This statement comes not from optometrists, but from the American Public Health Association. This association is made up of 32,000 members from various public health professionals including MD's and Ophthalmologists.

I wish to thank you on behalf of the Optometric Society of the District of Columbia and for allowing myself and my colleagues the opportunity to present our profession today. At the end of my colleagues' testimony, a panel will be available to answer any questions.

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I wish to thank you on behalf of the Optometric Society of the District of Columbia and for allowing myself and my colleagues the opportunity to present our profession today. At the end of my colleagues' testimony, a panel will be available to answer any questions.

TESTIMONY FOR DC BILL 12-152

May 28, 1997

Hello. My name is Dr. Steven Lee Schneid. I am a Doctor of Optometry and operate three offices in the DC Metropolitan area; one in Arlington, Virginia, one in Takoma Park, Maryland, and for the past 4 years, one in the Cleveland Park area of the District of Columbia. I am here today to ask for your support for Bill 12-152 which would redefine the scope of care Qualified Optometrists would be able to provide.

As the Nation's Capital, I feel it is important for the District of Columbia to be a leader in Health Care and pass legislation that not only changes its laws to match what 98% of the rest of America has already recognized but to move to the forefront of therapeutic care and approve the use of Therapeutic Pharmaceutical Agents, TPA's, to a level that equals the current standards of education for Doctors of Optometry.

Personally, I find it not only a time consuming, costly inconvenience for both my patients and I to have to ask them to travel to my offices outside the District for therapeutic eyecare but also a source of embarrassment having to constantly make excuses and explain the Districts current legal status. For the past 10 years I have practiced medically focused eyecare that has included the use of TPA's when legally permissable. The current DC law is clearly out-dated and to me it's unimaginable how almost every weekday evening, when I travel from my Arlington office to my DC office the scope of my practice is functionally reduced 10 fold and the quality of my education and Board certification is seemingly diminished as I cross the 14th Street Bridge.

As Primary Care Doctors, therapeutic licenses are based on completing extensive advanced training and comprehensive testing in order to establish competency to treat eye conditions with TPA's. Further training is required yearly to ensure that the highest quality care is provided and thus ensure that the rights of consumers are protected. To me, practicing Optometry to the fullest extent of my education and knowledge is an obligation.

The people of the District genuinely deserve the benefits that total Optometric care would provide and passing this law would give us the tools needed to do the job. Some of these benefits include access to a greater number of TPA certified doctors, reduced patient costs incurred with duplication of testing as a result from an unnecessary referral or as a result of having to travel to neighboring states to complete therapeutic care.

For reference, I have included in my testimony a synopsis of the proposed Bill, a list of dates of enactments of both DPA's, Diagnostic Pharmaceutical Agents, and TPA's, a United States map detailing current pharmaceutical legislature, and the most recent definition of Optometry. I hope you find this helpful.

Please give us the laws we need to provide DC with the best eyecare possible and vote for this bill! Thank you.

Dr. Steven Lee Schneid
Uptown Vision
3424 Connecticut Avenue, NW
Washington, DC 20008
(202) 363-2300

Dr. Steven Lee Schneid
Takoma Park Vision Center
6919 Laurel Avenue
Takoma Park, Maryland 20912
(301) 270-2020

Dr. Steven Lee Schneid
2805 Columbia Pike, Suite B
Arlington, Virginia 22204
(703) 486-2620

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Uptown Vision
3424 Connecticut Avenue, NW
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6919 Laurel Avenue
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Dr. Steven Lee Schneid
2805 Columbia Pike, Suite B
Arlington, Virginia 22204
(703) 486-2620

BILL 12-152 "Definition of Optometry Amendment Act of 1997"

SYNOPSIS:

-Bill 12-152 allows certified optometrist to treat eye disorders. This proposed amendment regulates optometry by restricting practice to the use of treatments and procedures subject to regulations defined by the Mayor and the Board of Optometry.

-Certification is subject to the regulations defined by the Mayor and the Board of Optometry.

LEGISLATIVE SUMMARY:

The amendment to the Optometry Act redefines optometry to include treatment of eye disorders.

1. Allows certified doctors of optometry to treat defects or abnormal conditions.
2. Allows certified doctors of optometry to use and prescribe therapeutic pharmaceutical agents.
3. Allows certified doctors of optometry to practice to the fullest extent of their education.
4. Allows certified doctors of optometry to practice at the same level in all states, with the exception of Massachusetts, including both Maryland and Virginia.

BENEFITS SUMMARY:

Cost

1. Patients have lower out of pocket expenses due to optometrists lower charges for like services and less duplication of fees by receiving treatment from the first examining doctor.
2. Insurance and government savings due to lower fees charged by optometrists for like services when compared with ophthalmologist.
3. Employers save due to less time required away from work because patients are treated at the first doctor visit.
4. Increased revenue for the District of Columbia government because more optometrist will desire to practice in an area where they can practice to the fullest extent of their training.

Access

1. Increased access due to greater numbers of certified doctors treating eye disorders.
2. Optometrists already examine greater than 60 percent of the population for primary eyecare, the patients are comfortable and familiar with optometrists.
3. Studies have indicated that optometric offices are open for patients more hours per week, more evenings and more weekends.
4. Increased access provides the citizens of Washington DC with faster and easier care.

STATE	DIAGNOSTIC USE	THERAPEUTIC USE
ALABAMA	*	June 20, 1995
ALASKA	May 25, 1988	June 11, 1992
ARIZONA	April 25, 1980	April 6, 1993
ARKANSAS	April 2, 1979	March 3, 1987
CALIFORNIA	July 9, 1976	February 20, 1996
COLORADO	June 10, 1983	April 20, 1988
CONNECTICUT	April 2, 1986	May 27, 1992
DELAWARE	July 10, 1975	June 30, 1994
D.C.	March 25, 1986	
FLORIDA	July 10, 1986**	July 10, 1986**
GEORGIA	February 14, 1980	February 25, 1988
GUAM	December 28, 1982	April 22, 1995
HAWAII	June 12, 1985	June 24, 1996
IDAHO	March 23, 1981	March 31, 1987
ILLINOIS	September 15, 1984	July 14, 1995
INDIANA	***	***
IOWA	June 8, 1979	May 31, 1985
KANSAS	April 12, 1977 (2:00 p.m.)	April 17, 1987
KENTUCKY	March 29, 1978	February 7, 1986
LOUISIANA	July 6, 1975	June 1, 1993
MAINE	June 24, 1975	June 25, 1987
MARYLAND	January 13, 1989	May 25, 1995
MASSACHUSETTS	December 23, 1985	
MICHIGAN	March 26, 1984	December 29, 1994
MINNESOTA	March 8, 1982	May 11, 1993
MISSISSIPPI	March 17, 1982	April 7, 1994
MISSOURI	July 24, 1981	June 24, 1986
MONTANA	April 12, 1977 (10:10 a.m.)	April 23, 1987
NEBRASKA	February 13, 1979	March 26, 1986
NEVADA	May 25, 1979	June 29, 1995
NEW HAMPSHIRE	June 6, 1985	June 29, 1993
NEW JERSEY	*	January 16, 1992
NEW MEXICO	March 4, 1977	April 5, 1985
NEW YORK	July 15, 1983	August 2, 1995
NORTH CAROLINA	June 3, 1977	June 3, 1977
NORTH DAKOTA	March 22, 1979	April 10, 1987
OHIO	March 15, 1984	February 15, 1992
OKLAHOMA	April 6, 1981	March 22, 1984
OREGON	May 20, 1975	August 9, 1991
PENNSYLVANIA	March 1, 1974	October 30, 1996
RHODE ISLAND	July 16, 1971	June 26, 1985
SOUTH CAROLINA	March 21, 1984	May 14, 1993
SOUTH DAKOTA	March 15, 1979	March 15, 1986
TENNESSEE	May 8, 1975	April 22, 1987
TEXAS	August 5, 1981	June 15, 1991
UTAH	March 21, 1979	March 20, 1991
VERMONT	April 23, 1984	June 20, 1994
VIRGINIA	February 25, 1983	April 11, 1988
WASHINGTON	April 23, 1981	April 18, 1989
WEST VIRGINIA	March 4, 1976	March 4, 1976
WISCONSIN	April 29, 1978	August 3, 1989
WYOMING	February 17, 1977	March 2, 1987

FOOTNOTE KEY:

** = General legislation, favorable attorney general opinion.*

*** = Previous favorable attorney general opinion. Specific legislation enacted in 1986.*

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DPA PHARMACEUTICAL LEGISLATION BY DATE OF ENACTMENT

1.	INDIANA	July 17, 1946* [AG Opinion]
2.	NEW JERSEY	May 22, 1968** [AG Opinion]
3.	RHODE ISLAND	July 16, 1971
4.	PENNSYLVANIA	March 1, 1974
5.	TENNESSEE	May 8, 1975
6.	OREGON	May 20, 1975
7.	MAINE	June 24, 1975
8.	LOUISIANA	July 6, 1975
9.	DELAWARE	July 10, 1975
10.	WEST VIRGINIA	March 4, 1976
11.	CALIFORNIA	July 9, 1976
12.	WYOMING	February 17, 1977
13.	NEW MEXICO	March 4, 1977
14.	MONTANA	April 12, 1977 (10:10 a.m.)
15.	KANSAS	April 12, 1977 (2:00 p.m.)
16.	NORTH CAROLINA	June 3, 1977
17.	KENTUCKY	March 29, 1978
18.	WISCONSIN	April 29, 1978
19.	NEBRASKA	February 13, 1979
20.	SOUTH DAKOTA	March 15, 1979
21.	UTAH	March 21, 1979
22.	NORTH DAKOTA	March 22, 1979
23.	ARKANSAS	April 2, 1979
24.	NEVADA	May 25, 1979
25.	IOWA	June 8, 1979
26.	GEORGIA	February 14, 1980
27.	ARIZONA	April 25, 1980
28.	IDAHO	March 23, 1981
29.	OKLAHOMA	April 6, 1981
30.	WASHINGTON	April 23, 1981
31.	MISSOURI	July 24, 1981
32.	TEXAS	August 5, 1981
33.	MINNESOTA	March 8, 1982
34.	MISSISSIPPI	March 17, 1982
35.	ALABAMA	September 30, 1982** [AG Opinion]
	GUAM	December 28, 1982
36.	VIRGINIA	February 25, 1983
37.	COLORADO	June 10, 1983
38.	NEW YORK	July 15, 1983
39.	OHIO	March 15, 1984
40.	SOUTH CAROLINA	March 21, 1984
41.	MICHIGAN	March 26, 1984
42.	VERMONT	April 23, 1984
43.	ILLINOIS	September 15, 1984
44.	NEW HAMPSHIRE	June 6, 1985
45.	HAWAII	June 12, 1985
46.	MASSACHUSETTS	December 23, 1985
	D.C.	March 25, 1986
47.	CONNECTICUT	April 2, 1986
48.	FLORIDA	July 10, 1986***
49.	ALASKA	May 25, 1988
50.	MARYLAND	January 13, 1989

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2.	NORTH CAROLINA	June 3, 1977
3.	INDIANA	*
4.	OKLAHOMA	March 22, 1984
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6.	IOWA	May 31, 1985
7.	RHODE ISLAND	June 26, 1985
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35.	SOUTH CAROLINA	May 14, 1993
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38.	MISSISSIPPI	April 7, 1994
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October 30, 1996

Status of Pharmaceutical Legislation

Diagnostic Use

Therapeutic and Diagnostic Use

The following are the definitions of Optometry/Optometrist modified and approved by the AOA Board of Trustees at its Board Meeting, April 24-25, 1997.

DEFINITION OF THE OPTOMETRIST

(Suitable for general use)

The optometrist is a health care professional trained and state licensed to provide primary eye care services. These services include comprehensive eye health and vision examinations; diagnosis and treatment of eye diseases and vision disorders; the detection of eye signs of general health problems; the prescribing of glasses, contact lenses, low vision rehabilitation and vision therapy; the prescribing of medications and performing of certain surgical procedures; and the counseling of patients regarding their vision needs as related to their occupations, avocations, lifestyle, and surgical alternatives. The optometrist has completed pre-professional undergraduate education in a college or university and four years of professional education at a college of optometry, leading to the doctor of optometry (O.D.) degree. Some optometrists complete a residency.

SHORT DEFINITION OF THE OPTOMETRIST

Optometrists are state-licensed health care professionals who diagnose and treat eye health and vision problems. They prescribe glasses, contact lenses, low vision rehabilitation, vision therapy and medications as well as perform certain surgical procedures. They hold the doctor of optometry (O.D.) degree.

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May 28, 1997

Testimony in support of bill 12-152 "Definition of Optometry Amendment act of 1997."

Good afternoon, my name is Bradford Dunn and I am the lead optometrist at Kaiser Permanente's West End Medical Center right around the corner on Pennsylvania Ave. I have been employed with Kaiser for the past two and half years after practicing optometry for ten years as an active duty officer in the United States Air Force.

It's my Air Force experience that I'd like to concentrate on today.

My first assignment was at Wilford Hall Medical Center in San Antonio, the Air Force's largest hospital, more than 1,500 beds. I was a member of the teaching staff of the Air Force's highly accredited Ophthalmology Residency program. In 1985, the year I entered the Air Force, Air Force optometrists were credentialed to use therapeutic medications in the treatment of ocular disease. By way of being on staff of an Ophthalmologic Residency program at the home of the Air Force's largest optometry and ophthalmology center I was intimately involved in the implementation of these privileges.

The Air Force saw clearly the reasoning behind allowing optometrists to practice to the full extent of their training. Optometry is a primary care profession. We see patients at an entry level into the medical system. This thinking went further with the Air Force powers at hand and optometry and ophthalmology were separated into different departments within a hospital. Ophthalmology fell under the Division of Surgery and Optometry fell under the Division of Primary Care. As primary care practitioners the Air Force gave optometrists the tools by which to provide primary care to eye patients, this certainly included therapeutic medicines.

Believe me, upon adoption of this model, eye care delivery in the Air Force was monitored closely for both quality of care and cost containment. The model worked; costs were reduced, time away from duty decreased, and patients were more satisfied with full scope care rather than the bureaucratic hassle of a referral.

This thinking went further into war time medicine planning. Optometrists, as primary care providers, are placed in what is known as second echelons of care. First echelon care is essentially front line first aid in the realm of battlefield medics.

Second echelon care is in support of the front line troops immediately behind the lines. This is where optometrists are fit into the picture. Certainly, the Air Force would not have professionals deemed essential to troop performance immediately behind battle lines restricting them from utilizing the medicines they are trained to use to treat ocular disease and/or injury.

I'm happy and more than just a little proud to say that Army and Air Force optometrists were deployed to the Saudi desert during Desert Storm and although, thank heavens, few injuries were a result of actual combat, the optometrists performed well in their primary care roles.

Ophthalmology is certainly essential in this picture but they are not primary eye care providers. In the Air Force model they are usually in the forth echelons of care, a major medical facility.

Please see the relevance of this "battlefield" model to the competitive nature of today's world of medical cost containment and our astute health care shopper. Patients expect, and deserve the best bang for their medicine dollar. They need and often demand the convenience and accessibility of one professional to service all their primary eye care needs.

All our professional careers we have been responsible for the diagnosis of ocular disease, sight threatening ocular disease. We have proved ourselves responsible in the past to detect this disease. We are now ready and qualified to treat this disease in the future.

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Respectfully Submitted Testimony in support of the "Definition of Optometry Amendment Act of 1997"

James D. Colgain, O.D.

I first want to state that I have lived and worked in the Washington DC area for most of my life, and all of my career as an optometrist. I have practiced in the District of Columbia, as both a military optometrist and the chief of optometry for Kaiser Permanente. As an optometrist, I have worked with therapeutic medications for most of my career and fully support the use of these medications when practicing in the District of Columbia.

I am currently the Regional General Manager for TLC The Laser Centers medical center operations from Virginia to Massachusetts. In addition, I am currently a Lieutenant Colonel in the District of Columbia Air National Guard and have served in the USAF and Air National Guard for fifteen years. From 1987 to 1996 I served as the Chief of Optometry for Kaiser Permanente's Mid Atlantic Region and currently serve on the Governor Glenndening's Quality Improvement task force to implement the therapeutics law in the state of Maryland. I was honored to be selected as optometrist of the year in the District of Columbia in 1990.

Throughout my career, I have taught optometry students, residents, and interns, as well as taught practicing optometrists in over 100 lectures and workshops. In addition, I have worked closely with primary care physicians and ophthalmologists in a variety of hospital and clinical settings.

The residents of the District of Columbia deserve the best in eye care in relation to access, cost effectiveness and quality. I would like to address those three items in this document.

Access to Quality Optometric Care

As the Chief of Optometry for Kaiser Permanente, I have interviewed hundreds of optometrists and was responsible for optometry recruitment in Maryland, Virginia and the District of Columbia Medical Centers. It was always much more difficult to recruit optometrists for our District of Columbia Centers than our medical centers in Virginia and Maryland. This was because the District of Columbia was the only jurisdiction that did not allow optometrist to use the full skills for which they are trained. Given a choice, the optometrists always preferred to work in a site where the state laws allowed them to treat their patients with therapeutic medications.

The District of Columbia's current law, restricting the use of therapeutic medications for optometrists, does not support the highest quality practitioners continuing to chose our nation's capital as the place to set up practice.

I also want to assure you as one who has visited over 25 HMOs nationwide, and who recruited in this area for over eight years, that as long as the District of Columbia does not provide an appropriate path for the Optometrists in DC to practice with therapeutics, you will find the number and caliber of optometric practitioner to slowly decline, and the number of licensees to dwindle in the ensuing years. Access to Eye care will suffer. Revenue for the District of Columbia will decrease from less licensing fees, and the 60% of citizens who depend on optometrists for their primary eye care, will experience delay in treatment, more time off of work, additional cost and have to needlessly be referred for conditions and diagnosis that Optometrists are trained to treat and manage.

Cost:

As the former Chief of Optometry at Kaiser Permanente, and a military officer, I have worked alongside of primary care physicians and ophthalmologists most of my career. Today's health care environment recognizes the cost of health care as a major concern for the patient, and the payers of health care. In studies at Kaiser Permanente, as well as in other HMOs across the country, where cost effectiveness of care and access to health care are major concerns, optometrists are encouraged to practice with therapeutic medications, as is consistent with their local state laws. HMOs and most all federal health care organizations would not encourage or allow the optometrists these privileges, if they did not deem it cost effective and continuing to meet the highest quality standards of their patients.

Most HMOs and other managed health care organizations, such as the veterans hospitals and military hospitals recognize the cost effectiveness of Optometrists providing the level of care they are trained to provide. In studies at Kaiser Permanente, we determined that when the cost per encounter to the health care system is compared between optometrists and ophthalmologists, it costs about 2.5 times <u>less</u> for the health care system to have a patient cared for by an optometrist than by an ophthalmologist. This could make a significant difference in the District of Columbia's cost for health, when factoring in the demographics and demand for eye health care, as the population ages in the next century

There are other "costs" to our patients by not having optometrists provide primary eye care, with therapeutics, as they are trained to provide. Patients, who in almost all other states in the country, could be treated by the optometrists, must be referred on to a specialist, or in many cases to a primary care physician, who has much less training, and almost no specialized equipment to diagnose and follow patients with eye disease. It is my experience that patients, when

The District of Columbia's current law, restricting the use of therapeutic medications for optometrists, does not support the highest quality practitioners continuing to chose our nation's capital as the place to set up practice.

I also want to assure you as one who has visited over 25 HMOs nationwide, and who recruited in this area for over eight years, that as long as the District of Columbia does not provide an appropriate path for the Optometrists in DC to practice with therapeutics, you will find the number and caliber of optometric practitioner to slowly decline, and the number of licensees to dwindle in the ensuing years. Access to Eye care will suffer. Revenue for the District of Columbia will decrease from less licensing fees, and the 60% of citizens who depend on optometrists for their primary eye care, will experience delay in treatment, more time off of work, additional cost and have to needlessly be referred for conditions and diagnosis that Optometrists are trained to treat and manage.

Cost:

As the former Chief of Optometry at Kaiser Permanente, and a military officer, I have worked alongside of primary care physicians and ophthalmologists most of my career. Today's health care environment recognizes the cost of health care as a major concern for the patient, and the payers of health care. In studies at Kaiser Permanente, as well as in other HMOs across the country, where cost effectiveness of care and access to health care are major concerns, optometrists are encouraged to practice with therapeutic medications, as is consistent with their local state laws. HMOs and most all federal health care organizations would not encourage or allow the optometrists these privileges, if they did not deem it cost effective and continuing to meet the highest quality standards of their patients.

Most HMOs and other managed health care organizations, such as the veterans hospitals and military hospitals recognize the cost effectiveness of Optometrists providing the level of care they are trained to provide. In studies at Kaiser Permanente, we determined that when the cost per encounter to the health care system is compared between optometrists and ophthalmologists, it costs about 2.5 times <u>less</u> for the health care system to have a patient cared for by an optometrist than by an ophthalmologist. This could make a significant difference in the District of Columbia's cost for health, when factoring in the demographics and demand for eye health care, as the population ages in the next century

There are other "costs" to our patients by not having optometrists provide primary eye care, with therapeutics, as they are trained to provide. Patients, who in almost all other states in the country, could be treated by the optometrists, must be referred on to a specialist, or in many cases to a primary care physician, who has much less training, and almost no specialized equipment to diagnose and follow patients with eye disease. It is my experience that patients, when

referred, do not always keep appointments, since transportation, access to appointments with the other doctor, cost of another visit, child care, and time off of work, become barriers to the these patients in keeping their appointments. It was our experience in the medical center in the District of Columbia for our HMO, that many of the patients referred on for specialty care failed to keep their appointments. Tremendous effort was placed on assuring that the patients who were referred on for care from an optometrist to an ophthalmologist, actually kept their appointment.

Quality:

The opposition to this initiative will site the degradation of quality of eye care, if optometrists are allowed to treat certain eye diseases in the district of Columbia. This was the same argument that was used when diagnostic drugs to dilate the eye were passed in 50 states and the District of Columbia and the same argument that has been used to try to block the other 49 states in the country who now or will soon allow optometrists to use these medications. Optometrists have been trained to use these medications since the 1970s and in many states across the country, have been using these medications for 20 years or more. In each case, if the quality of eye care actually did degrade in these states, our litigious society would respond by initiating lawsuits or the laws would of been rescinded. Just the opposite has happened. No law allowing optometrists to treat eye diseases has ever been rescinded or restricted and in many states, these laws have been expanded to allow additional management of ocular disease.

The malpractice insurance industry runs their numbers every year and has determined that when optometrists have earned the right to use therapeutic medications, the ensuing years have either seen a leveling of malpractice premiums, or an actual decline in some of those premiums. The actuarial in the malpractice insurance companies have no political bent on this issue. If quality of eye care was actually degraded, and ended up causing the damage to patients that our opposition states will occur, then why has this not happened in the other states, where optometrists have been treating eye diseases for decades?

Preparation and Training of Optometrists to Treat Eye Disease:

I have been involved in optometric education for a majority of my professional life. This has included the clinical teaching and mentoring of optometry interns, students and residents in various hospitals, clinics and offices. It is my opinion as one involved in education that optometrists recognize the limit of their skill and refer their patients for further care, to the appropriate provider. It is my experience with the Optometrists in the District of Columbia, that they

recognize the availability of specialists in this area and will consult, refer, and manage their patients to the best outcome for their particular diagnosis.

The training of optometrists by the schools and colleges of optometry and through rigorous and required continuing education, has prepared the practicing optometrist for this responsibility. This is not a new responsibility, it is simply new in the District of Columbia. Opposition to this licensing may raise concerns about unqualified optometrists taking on responsibility for patients that outstrips their experience and qualifications. Once again, the experience of other states does not bear this out. Those optometrists who are unwilling to complete the required training, will make their own choice not to manage these patients in their offices or to use therapeutic medications.

In conclusion, as one who was born in the District of Columbia and has practiced in the District of Columbia and surrounding area for 14 years, I wish to emphasize that this effort, to allow me to use therapeutic medications in the District of Columbia, is simply enabling me to practice optometry the way I have in other states, for well over a decade. The essence of any health care professional is to recognize that their patient's welfare is their primary concern, and the overriding driver for all decisions regarding their decisions. The ability to use the medications for which I am trained, in my patient's best interest, is the reason I support this legislation.

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May 28, 1997

My name is Dr. John Minardi. I am a doctor of optometry who currently practices at the George Washington University Refractive Laser Center. I provide patient care in Towson and Bethesda, Maryland, and also in Tyson's Corner, Virginia.

Prior to my current mode of practice, I spent two years on staff at the Bascom Palmer Eye Institute of the University of Miami Medical School. I practiced primary eye care at an ophthalmology group practice in the District of Columbia for six years. I also spent three years on staff at Kaiser Permanente in Maryland and the District of Columbia.

I served two terms as the President of the Optometric Society of the District of Columbia and one term as the Chairman of the Optometric Council of the National Capital Region.

I am here today to describe why this proposed bill will benefit the consumers of the District of Columbia. Currently, an optometrist in the District of Columbia who examines a patient with an eye infection or minor trauma must diagnose the problem and then refer that patient to an MD for treatment. Referring patients for the treatment of common eye ailments results in duplication of diagnostic procedures, patient delay in receiving needed treatment, discontinuity of care, additional time lost from work, and significant additional fees to patients. When a patient of mine who lives or works in the District of Columbia has an eye problem that requires treatment, that patient must travel to my Maryland or Virginia office for appropriate care or be referred to an MD in the District for treatment. If this situation should occur on a weekend, the patient would have to be sent to the hospital emergency room as most medical offices do not have weekend office hours.

Emergency room care is far more expensive for the same services that optometrists are trained and qualified to provide. For example, a study in Massachusetts in 1989 showed that 74,554 cases of superficial eye problems were treated in emergency rooms at a cost of $9,800,000. If these services had been provided by optometrists licensed to use therapeutic pharmaceuticals, the people of Massachusetts would have spent only $3,000,000, resulting in a net savings of $6,800,000 in health care costs.

Optometrists are qualified to provide primary eye care. Primary eye care includes the use of therapeutic pharmaceutical agents in the treatment of infection, uncomplicated glaucoma, and other problems routinely handled by primary care physicians. The possession of and use of sophisticated equipment such as the binocular indirect ophthalmoscope, applanation tonometer, gonioprism, and visual field equipment is far superior in a modern optometric practice than in any other primary care physician's office such as family practice physicians, internists, and pediatricians. The training and experience in the use of this type of equipment make the optometrist far better qualified to evaluate, diagnose, and treat most ocular conditions when compared to the other primary health care providers listed above.

JAY L. HELFGOTT, M.D. (1914-1981)

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296-4900

DATE: 23 May 97

TIME: 15 15

PAGES TO FOLLOW: 1

TO: Ms. Sabrina [illegible]

COMPANY: Council of the District of Columbia

LOCATION: 13th [illegible]

FAX: 724 8157 PHONE: [illegible]

FROM: M.A. Helfgott

COMPANY: Helfgott & Fine, M.D., P.C.

LOCATION: 1133 20th Street, N.W.; # B150; Washington, DC 20036

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NOTE

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NOTE

May 23, 1997

To whom it may concern:

Below is an outline of the testimony that I plan to present to the Committee on consumer and Regulatory Affairs regarding the "Definition of Optometry Amendment Act of 1997", Bill 12-152, on Wednesday May 28, 1997.

C.V. Name: Maxwell A. Helfgott, M.D.
Title: Chairman, Department of Ophthalmology, Washington Hospital Center
Past President, Washington Ophthalmological Society
Born: Washington, D.C. Resident: Bethesda, Maryland
Work Address: 1133 20th Street, N.W. #B-150
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I. Role of Government in Regulation of Professional Activities
   a. Protection of the Public Interest and Safety
      Set Standards for Entry of New Practitioners; Encourage Uniformity of Services by Practitioners; Create Procedures for Disciplining Existing Practitioners
   b. Control Distribution and Access to Services
      Concentrate or Disperse in Specified Locales; Encourage or Discourage Public Access; Enhance or Diminish Practitioners Competition and Control
   c. Generate Revenue
      License Fees, Franchise Tax; Special Taxes

II. Examples of Professional Regulation by Government
   Airline Pilots/Private Pilots; Prostitution; Attorneys; River Boat Pilots

III. Definition of the Healing Arts in the District of Columbia and Elsewhere
   a. Special Post-graduate Education
      Independently Accredited Educational Program with Basic Testing for Licensure *after* Accredited Educational Program
   b. Diagnosis and Treatment of Human Illness
      Definition of Physician; Definition of Surgery
   c. Self-Regulation and Scope of Practice Defined Within the Context of *Hospital* Medical Staff Regulation

V. Recommendations Regarding the Definition of Optometry Bill
   a. Define Surgery unequivocally
   b. Review the experience of non-commercial staff model practices, i.e., the military, Staff model HMO's, University Health Plans, etc.
   c. Restructure the Licensing Authority in D.C. to cover all aspects of the Healing Arts, and let that body define scope of practice of various professions.
   d. Define the purpose of this legislation, as to Public Safety, Public Access, Educational Standards, Licensure Testing, etc.
   e. Recognize that Medicine and Optometry have legitimate interests in providing high quality eye care to our patients. Let the two groups work this out under the supervision of the Healing Arts Commission.

GEORGETOWN UNIVERSITY MEDICAL CENTER

Center for Sight
Department of Ophthalmology
Howard P. Cupples, MD
Chairman
Jocelyn Fenwick Jones
Administrator

Cornea & Refractive
Surgery Service
Jay M. Lustbader, MD

Glaucoma Service
Deborah Y. Wilson, MD

Low Vision Service
Andrew J. Adelson, MD

Neuro-Ophthalmology
Georgia A. Chrousos, MD

Orbital, Lacrimal, &
Reconstructive Surgery
Timothy J. Malone, MD

Pediatric Ophthalmology
& Strabismus
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Retina & Vitreous Service
Claude L. Cowan, Jr., MD
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David G. Wagner, MD

Uveitis
David J. Forster, MD

Ophthalmic Medical Personnel
Training Program
Phyllis L. Fineberg, COMT
Peter Y. Evans, MD

Photography & Special
Studies
Denise Cunningham, COPRA

D.C. General Hospital
Sasikala Pillai, MD

VA Medical Center
Claude L. Cowan, Jr., MD

Good afternoon, Chairperson Brazil and members of the Committee on Consumer and Regulatory Affairs. I want to thank you for the opportunity to testify on the "Definition of Optometry Act of 1997," Bill 12-152.

I am Dr. Howard Cupples, Professor and Chairman of the Department of Ophthalmology, Georgetown University Medical School. I am responsible for the ophthalmological education of medical students, supervise the residency program in ophthalmology, and manage the post-resident fellowships in ophthalmology. It is from the prospective of education and concern for patient welfare that prompts me to voice caution in those portions of the Bill concerning the use therapeutic medications and those concerning surgery.

There are important points that must be understood about the education of these two professions.

1. The number of years of training after college to become an ophthalmologist is eight. The number of years of training after college to become an optometrist is four.

2. The minimum didactic curriculum of the first two years of medical school is 2,000 hours of which at least 1,250 hours must be in basic and clinical sciences. The didactic curriculum of the first three years of optometry school averages 1,700 hours of which 380 hours is in basic and clinical sciences.

3. The minimum requirements for the third and fourth years of medical school involves 2,000 hours in basic medical speciality services, plus 1,200 hours in elective rotations. The fourth year of optometry school involves clinical experience of an average of 2,000 hours.

4. A fifth year post-graduate hospital internship is required for all ophthalmologists. Average patient contact is 3,000 hours. None is required for an optometrist.

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5. A required 36 month residency in ophthalmology (maximum 80 hours per week), to include a minimum of 360 hours in didactic education in basic and clinical sciences and 50 hours in pathology. The minimum patient requirements include 3,000 outpatient visits which must include at least 1,500 refractions and 2,000 patients which have eye disease. The minimum surgical requirements include 25 cataract and 10 strabismus surgeries. The must be a minimum of 288 hours of clinical conferences. The program must be accredited by the Accreditation Council for Graduate Medical Education. No equivalent post-graduate program exists for optometry.

6. Optometrists may wish to stress the number of hours that they have listened to pharmacology lectures. However, pharmacology is only mastered when patients are seen, examined and treated. This is where the effects of medications are seen, side effects evaluated and managed, and therapy must be changed and tailored to the patient's needs and other systemic medical conditions. The ophthalmologist has continued experience which begins in the last two years of medical school, continues through internship and throughout the three years of ophthalmology residency. The ophthalmologist will see, examine and treat an average of 8,100 patients in his training. The average number of patients with eye disease seen during optometric training is 150.

The welfare of the patient should be of primary concern. The public already assumes a basic level of competence in the unrestricted treatment of eye disease from ophthalmologists. To require less training, skill and expertise of another group would be a breach of the trust that the patient has a right to expect.

Thank you for the opportunity to address the Council and express my concerns.

Testimony of the
Medical Society of the District of Columbia

on
Bill 12-152, the "Definition of Optometry Amendment Act of 1997"

before the
Committee on Consumer and Regulatory Affairs
Harold Brazil, Chairman

Wednesday, May 28, 1997

Samuel S. Stopak, MD

Testimony of the
Medical Society of the District of Columbia

on

Bill 12-152, the "Definition of Optometry Amendment Act of 1997"

before the
Committee on Consumer and Regulatory Affairs
Harold Brazil, Chairman

Wednesday, May 28, 1997

Samuel S. Stopak, MD

Good afternoon, Chairman Brazil and members of the Committee on Consumer and Regulatory Affairs. My name is Dr. Samuel Stopak and I am here to testify this afternoon on behalf of the Medical Society of the District of Columbia. I am a practicing ophthalmologist in the District of Columbia. I am the Immediate Past President of the Washington Ophthalmology Society and have served as Chair of the Medical Society's Ophthalmology Section.

First, I want to thank you for scheduling these public hearings on Bill 12-152, the "Definition of Optometry Amendment Act of 1997." This is not the first time that the Council has focused on the subject matter of this bill. Approximately two years ago, there was discussion among ophthalmologists and optometrists regarding this important legislation.

The Medical Society of the District of Columbia, and the Washington Ophthalmology Society agree with the basic concept

of the bill: there needs to be clear delineation of the practice scope of optometrists and ophthalmologists. There are, however, critical areas of the legislation which concern us. Most importantly, we feel that the bill is too vague and does not specify necessary distinctions about the practice of optometry. For instance, with respect to surgical applications, the bill, while mentioning some limitations, implies that laser surgery is not invasive surgery and therefore may be conducted by an optometrist. According to research by the American Academy of Ophthalmology, no legislature has ever specifically authorized optometrists to perform laser surgery. It is our strong belief, based on scientific principles, that laser surgery is, in fact, an invasive surgical procedure, which should not be conducted by anyone other than a trained medical doctor of ophthalmology. Presently, 47 states prohibit optometric surgery, with 36 of those states specifically prohibiting optometric laser surgery. We believe that language should be added to Bill

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12-152 defining all laser procedures as surgery and eliminating the possibility of optometrists performing any surgery.

We are also concerned that the legislation is unrestrictive with respect to the dispensing of medications. This is problematic. It is in the best interest of the public to clearly state that limitations on prescriptive privileges should and do exist. First, systemic medications of any kind should only be prescribed by a medical doctor of ophthalmology. Second, topical therapeutic agents vary widely in their applications for disease and effects on the eye and body. We recommend adding to the legislation, language outlining prohibitions on the use of topic therapeutic medications, such that those with the most harmful side effects and those used to treat the most acutely dangerous diseases be specifically recognized as not for use by optometrists. Clearly, some distinction must be made such that complicated, sight-threatening conditions are reserved for treatment solely by ophthalmologists, who have the extensive

training and experience necessary to administer this patient care. Virtually all states have some limitations in this regard.

Chairman Brazil and members of the Committee, I bring to your attention the fact that there are numerous compromise bills enacted by legislatures across the country that would rectify the current problems that exist in this current legislation. For example, in Maryland, topical steroids, fortified antibiotics, topical antiviral, and antifungal agents are prohibited. The use of glaucoma eyedrops are used only with co-management arrangements with an ophthalmologist. In Virginia, similar limitations are included along with detailed therapeutic licensing criteria which must be met by dispensing optometrists. Attached for your review are copies of the Maryland and Virginia bills, along with several pages outlining optometric scope of practice statutory restrictions.

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In order to implement the aforementioned changes, Bill 12-152 should be amended in the following places: page 1, lines 16-19, page 2, lines 1 and 9, and page 3, lines 1-3.

Finally, I recommend the use of the term "physician" on page 2, line 13 be eliminated and that this term be reserved solely for references to doctors with a medical degree.

It is critical for me as an Ophthalmologist to provide the highest level of care to my patients. Over thirteen years ago I chose training and education beyond optometry training in order to render such care. While it is clear that an individual has a CHOICE to practice optometry versus ophthalmology, we must not allow similar fields with vastly different levels of training to suddenly be given comparable privileges. Such would be a disservice to patient care and to the community. In addition, given the increased surge of managed care organizations, and the

concerns physicians have with respect to contractual language, it is imperative that the scope of practice for ophthalmologists and optometrists be clearly and sufficiently defined. Anything short of this puts medical care at risk. The citizens of the District must be protected.

In closing, I must stress that the Medical Society of the District of Columbia stands ready to support a bill which clearly defines the scope of the practice of optometry in the District of Columbia, but contains the appropriate restrictions on such a practice.

I thank you again, for this opportunity to address the Council. I will be happy to entertain any questions you may have of me at this time.

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SENATE BILL 454

J2

5lr1858
CF 5lr1145

By: Senators Dorman, Teitelbaum, Sfikas, Craig, and Pinsky
Introduced and read first time: February 3, 1995
Assigned to: Economic and Environmental Affairs

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 24, 1995

CHAPTER 0521 MAY 25 '95

AN ACT concerning APPROVED BY THE GOVERNOR

Optometrists – ~~Therapeutic Pharmaceutical Agents~~ Scope of Practice

FOR the purpose of requiring the State Board of Examiners in Optometry (Board) to maintain a list of certain information; authorizing the Board to set reasonable fees for the issuance and renewal of certain certificates; requiring the Board to establish certain continuing education requirements; requiring the Secretary of Health and Mental Hygiene to establish a certain quality assurance program and adopt certain regulations; requiring optometrists to refer patients to certain health care providers under certain circumstances; authorizing the use of a certain ~~title~~ titles; making a certain exception; requiring the Board to certify a licensed optometrist as a diagnostically certified optometrist under certain circumstances; requiring the Board to certify a licensed optometrist as a therapeutically certified optometrist under certain circumstances; authorizing ~~diagnostically~~ therapeutically certified optometrists to administer and prescribe certain therapeutic pharmaceutical agents ~~and to~~, remove certain foreign bodies from the human eye ~~and adnexa~~, and perform certain other therapeutic tasks; prohibiting the performance of certain procedures; defining certain terms; altering certain definitions; making the provisions of this Act severable; and generally relating to ~~the administering and prescribing of therapeutic pharmaceutical agents and the removal of foreign bodies from the human eye and adnexa by therapeutically~~ the scope of practice of therapeutically and diagnostically certified optometrists.

BY repealing and reenacting, with amendments,
Article – Health Occupations
Section 11–101, 11–205(b), 11–207(b), 11–309, 11–402, 11–403, and 11–404
Annotated Code of Maryland
(1994 Replacement Volume)

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike-out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

BY adding to
Article – Health Occupations
Section 11–404.1, 11–404.2, 11–404.3, and 11–503
Annotated Code of Maryland
(1994 Replacement Volume)

Preamble

WHEREAS, The General Assembly, in enacting this Act, has sought the input and cooperation of the Maryland Optometric Association, the Maryland Society of Eye Physicians and Surgeons, and the Secretary of the Department of Health and Mental Hygiene; and

WHEREAS, The Maryland Optometric Association, the Maryland Society of Eye Physicians and Surgeons, and the Secretary of the Department of Health and Mental Hygiene have agreed not to seek nor support before the General Assembly any expansion in the law regarding the scope of optometric practice until at least January 1, 2000; and

WHEREAS, It is the intent of the General Assembly to expand the scope of optometric practice only to the extent specified in this Act; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health Occupations

11–101.

(a) In this title the following words have the meanings indicated.

(b) "Board" means the State Board of Examiners in Optometry.

(C) "DIAGNOSTICALLY CERTIFIED OPTOMETRIST" MEANS A LICENSED OPTOMETRIST WHO IS CERTIFIED BY THE BOARD TO ADMINISTER TOPICAL OCULAR DIAGNOSTIC PHARMACEUTICAL AGENTS ~~SUBJECT TO~~ TO THE EXTENT PERMITTED UNDER § 11–404 OF THIS TITLE.

[(c)] (D) "License" means, unless the context requires otherwise, a license issued by the Board to practice optometry.

[(d)] (E) "Licensed optometrist" means, unless the context requires otherwise, an optometrist who is licensed by the Board to practice optometry.

[(e)] (F) "Optometrist" means an individual who practices optometry.

[(f)] (G) (1) "Practice optometry" means:

[(1)] (I) ~~[~~Subject to ~~§ 11–404~~ §§ 11–404 AND 11–404.2 of this title, to~~]~~ ~~TO~~ use any means known in the ~~[~~science~~]~~ ~~SCIENCES~~ of optics, ~~VISION CARE,~~ OR EYE CARE, except surgery:

BY adding to
Article – Health Occupations
Section 11–404.1, 11–404.2, 11–404.3, and 11–503
Annotated Code of Maryland
(1994 Replacement Volume)

Preamble

WHEREAS, The General Assembly, in enacting this Act, has sought the input and cooperation of the Maryland Optometric Association, the Maryland Society of Eye Physicians and Surgeons, and the Secretary of the Department of Health and Mental Hygiene; and

WHEREAS, The Maryland Optometric Association, the Maryland Society of Eye Physicians and Surgeons, and the Secretary of the Department of Health and Mental Hygiene have agreed not to seek nor support before the General Assembly any expansion in the law regarding the scope of optometric practice until at least January 1, 2000; and

WHEREAS, It is the intent of the General Assembly to expand the scope of optometric practice only to the extent specified in this Act; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health Occupations

11–101.

(a) In this title the following words have the meanings indicated.

(b) "Board" means the State Board of Examiners in Optometry.

(C) "DIAGNOSTICALLY CERTIFIED OPTOMETRIST" MEANS A LICENSED OPTOMETRIST WHO IS CERTIFIED BY THE BOARD TO ADMINISTER TOPICAL OCULAR DIAGNOSTIC PHARMACEUTICAL AGENTS ~~SUBJECT TO~~ TO THE EXTENT PERMITTED UNDER § 11–404 OF THIS TITLE.

[(c)] (D) "License" means, unless the context requires otherwise, a license issued by the Board to practice optometry.

[(d)] (E) "Licensed optometrist" means, unless the context requires otherwise, an optometrist who is licensed by the Board to practice optometry.

[(e)] (F) "Optometrist" means an individual who practices optometry.

[(f)] (G) (1) "Practice optometry" means:

[(1)] (I) ~~[~~Subject to ~~§ 11–404~~ §§ 11–404 AND 11–404.2 of this title; to~~]~~ ~~TO~~ use any means known in the ~~[~~science~~]~~ ~~SCIENCES~~ of optics~~, VISION CARE,~~ OR EYE CARE, except surgery:

[(i)] 1. To detect, DIAGNOSE, AND SUBJECT TO ~~§ 11–404.1~~ §§ 11–404 AND 11–404.2 OF THIS TITLE, TREAT, SUBJECT TO THIS TITLE, any optical, ~~VISUAL,~~ or diseased condition in the human eye ~~AND ADNEXA, OR THE VISUAL SYSTEM~~; or

[(ii)] 2. To prescribe eyeglasses or lenses to correct any optical OR VISUAL condition in the human eye;

[(2)](II) To give advice or direction on the fitness or adaptation of eyeglasses or lenses to any individual for the correction or relief of a condition for which eyeglasses or lenses are worn; or

[(3)](III) To use or permit the use of any instrument, test card, test type, test eyeglasses, test lenses, or other device to aid in choosing eyeglasses or lenses for an individual to wear.

(2) SUBJECT TO §§ 11–404 AND ~~11–404.1~~ 11–404.2 OF THIS TITLE, "PRACTICE OPTOMETRY" INCLUDES:

(I) THE ADMINISTRATION OF TOPICAL OCULAR DIAGNOSTIC PHARMACEUTICAL AGENTS; ~~OR~~

(II) THE ADMINISTRATION AND PRESCRIPTION OF THERAPEUTIC PHARMACEUTICAL AGENTS ~~AND THE REMOVAL OF SUPERFICIAL FOREIGN BODIES FROM THE HUMAN EYE AND ADNEXA; AND~~

(III) THE REMOVAL OF SUPERFICIAL FOREIGN BODIES FROM THE CORNEA AND CONJUNCTIVA.

(H) "THERAPEUTICALLY CERTIFIED OPTOMETRIST" MEANS A LICENSED OPTOMETRIST WHO IS CERTIFIED BY THE BOARD TO ~~ADMINISTER AND PRESCRIBE THERAPEUTIC PHARMACEUTICAL AGENTS AND WHO MAY REMOVE SUPERFICIAL FOREIGN BODIES FROM THE HUMAN EYE AND ADNEXA SUBJECT TO § 11–404.1~~ PRACTICE OPTOMETRY TO THE EXTENT PERMITTED UNDER § 11–404.2 OF THIS TITLE.

11–205.

(b) In addition to the duties set forth elsewhere in this title, the Board shall:

(1) Keep a current list showing all:

(i) Licensed optometrists;

(ii) Optometrists who are on inactive status; [and]

~~(III) OPTOMETRISTS WHO ARE CERTIFIED TO ADMINISTER TOPICAL OCULAR DIAGNOSTIC PHARMACEUTICAL AGENTS IN ACCORDANCE WITH § 11–404 OF THIS TITLE;~~

~~(IV) OPTOMETRISTS WHO ARE CERTIFIED TO ADMINISTER AND PRESCRIBE THERAPEUTIC PHARMACEUTICAL AGENTS AND REMOVE SUPERFICIAL FOREIGN BODIES FROM THE HUMAN EYE AND ADNEXA IN ACCORDANCE WITH § 11–404.1 OF THIS TITLE; AND~~

(III) DIAGNOSTICALLY CERTIFIED OPTOMETRISTS;

(IV) THERAPEUTICALLY CERTIFIED OPTOMETRISTS; AND

[(iii)](V) Optometrists against whom action has been taken under § 11–313 of this title;

(2) Keep a full record of its proceedings; and

(3) Adopt an official seal.

11–207.

(b) (1) The Board may set reasonable fees for the issuance and renewal of licenses AND CERTIFICATES and its other services.

(2) The fees charged shall be set so as to produce funds to approximate the cost of maintaining the Board.

(3) Funds to cover the compensation and expenses of the Board members shall be generated by fees set under this section.

11–309.

(a) In addition to any other qualifications and requirements established by the Board, the Board shall establish continuing education requirements as a condition to the renewal of licenses AND CERTIFICATES under this title.

(b) (1) The continuing education required by the Board shall be in courses approved by the Board.

(2) The Board may not require a ~~licensee~~ NONTHERAPEUTICALLY CERTIFIED OPTOMETRIST to attend more than [25] 50 hours in any [license year] LICENSING PERIOD~~, EXCEPT THAT A THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL ATTEND AT LEAST 6 ADDITIONAL HOURS OF INSTRUCTION IN PHARMACOLOGY IN ACCORDANCE WITH § 11–404.1(C) OF THIS TITLE~~.

(3) THE BOARD SHALL REQUIRE A THERAPEUTICALLY CERTIFIED OPTOMETRIST TO ATTEND AT LEAST 50 HOURS OF CONTINUING EDUCATION IN A LICENSING PERIOD.

(4) (I) IN EACH LICENSING PERIOD, A THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL ATTEND 30 HOURS OF CONTINUING EDUCATION ON THE USE AND MANAGEMENT OF THERAPEUTIC PHARMACEUTICAL AGENTS.

(II) THE 30 HOURS OF CONTINUING EDUCATION REQUIRED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL BE COUNTED TOWARD THE TOTAL NUMBER OF REQUIRED HOURS OF CONTINUING EDUCATION IN A LICENSING PERIOD.

(c) At the time a licensee applies for license renewal, the licensee shall submit to the Board, on a form provided by the Board, a certification that the licensee has attended the required courses.

(d) The Board may refuse to renew the license of a licensee who has failed:

(1) To attend the required courses; or

(IV) THERAPEUTICALLY CERTIFIED OPTOMETRISTS; AND

[(iii)](V) Optometrists against whom action has been taken under § 11–313 of this title;

(2) Keep a full record of its proceedings; and

(3) Adopt an official seal.

11–207.

(b) (1) The Board may set reasonable fees for the issuance and renewal of licenses AND CERTIFICATES and its other services.

(2) The fees charged shall be set so as to produce funds to approximate the cost of maintaining the Board.

(3) Funds to cover the compensation and expenses of the Board members shall be generated by fees set under this section.

11–309.

(a) In addition to any other qualifications and requirements established by the Board, the Board shall establish continuing education requirements as a condition to the renewal of licenses AND CERTIFICATES under this title.

(b) (1) The continuing education required by the Board shall be in courses approved by the Board.

(2) The Board may not require a ~~licensee~~ NONTHERAPEUTICALLY CERTIFIED OPTOMETRIST to attend more than [25] 50 hours in any [license year] LICENSING PERIOD, ~~EXCEPT THAT A THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL ATTEND AT LEAST 6 ADDITIONAL HOURS OF INSTRUCTION IN PHARMACOLOGY IN ACCORDANCE WITH § 11–404.1(C) OF THIS TITLE~~.

(3) THE BOARD SHALL REQUIRE A THERAPEUTICALLY CERTIFIED OPTOMETRIST TO ATTEND AT LEAST 50 HOURS OF CONTINUING EDUCATION IN A LICENSING PERIOD.

(4) (I) IN EACH LICENSING PERIOD, A THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL ATTEND 30 HOURS OF CONTINUING EDUCATION ON THE USE AND MANAGEMENT OF THERAPEUTIC PHARMACEUTICAL AGENTS.

(II) THE 30 HOURS OF CONTINUING EDUCATION REQUIRED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL BE COUNTED TOWARD THE TOTAL NUMBER OF REQUIRED HOURS OF CONTINUING EDUCATION IN A LICENSING PERIOD.

(c) At the time a licensee applies for license renewal, the licensee shall submit to the Board, on a form provided by the Board, a certification that the licensee has attended the required courses.

(d) The Board may refuse to renew the license of a licensee who has failed:

(1) To attend the required courses; or

(2) To submit certification of attendance at the required courses.

(e) The Board may waive the continuing education requirements in cases of illness or other undue hardship on the licensee.

(f) The Board may use any funds allocated to it for continuing education as State funds to match federal funds for providing continuing education.

11–402.

(A) If, while providing optometric services to a patient, an optometrist OR DIAGNOSTICALLY CERTIFIED OPTOMETRIST **detects** OR DIAGNOSES **an active eye pathology** WHICH THE OPTOMETRIST IS NOT LICENSED OR CERTIFIED TO TREAT UNDER ~~§ 11–404.1~~ § 11–404 OR § 11–404.2 OF THIS SUBTITLE, **the optometrist shall refer the patient to** ~~a physician OR ANOTHER APPROPRIATELY LICENSED HEALTH CARE PROVIDER~~:

(1) AN OPHTHALMOLOGIST OR A THERAPEUTICALLY CERTIFIED OPTOMETRIST, AS APPROPRIATE;

(2) THE PATIENT'S PHYSICIAN;

(3) A PHYSICIAN IF REQUIRED UNDER A MANAGED CARE CONTRACT; OR

(4) A HOSPITAL EMERGENCY ROOM OR AMBULATORY SURGICAL CENTER IF NECESSARY.

(B) IF, WHILE PROVIDING OPTOMETRIC SERVICES TO A PATIENT, A THERAPEUTICALLY CERTIFIED OPTOMETRIST DIAGNOSES AN ACTIVE EYE PATHOLOGY THAT THE OPTOMETRIST IS NOT CERTIFIED TO TREAT UNDER § 11–404.2 OF THIS SUBTITLE, THE OPTOMETRIST SHALL REFER THE PATIENT TO:

(1) AN OPHTHALMOLOGIST;

(2) THE PATIENT'S PHYSICIAN;

(3) A PHYSICIAN IF REQUIRED UNDER A MANAGED CARE CONTRACT; OR

(4) A HOSPITAL EMERGENCY ROOM IF NECESSARY.

11–403.

(a) A licensed optometrist may:

(1) Use the title "optometrist"; [and]

(2) If the optometrist holds the degree of doctor of optics or doctor of optometry from a college or university authorized to give the degree, use the title "Doctor" or the abbreviations "Dr." or "O.D." with the optometrist's name[.]; ~~AND~~

(3) IF THE OPTOMETRIST IS CERTIFIED UNDER § 11–404 OF THIS SUBTITLE, USE THE TITLE "DIAGNOSTICALLY CERTIFIED OPTOMETRIST"; AND

~~(3)~~ (4) IF THE OPTOMETRIST IS CERTIFIED UNDER § 11–404 OF THIS SUBTITLE, USE THE TITLE "THERAPEUTICALLY CERTIFIED OPTOMETRIST".

(b) Except as otherwise provided in this section, a licensed optometrist may not attach to the optometrist's name or use as a title:

(1) The words or abbreviations "Doctor", "Dr.", "M.D.", "physician", or "surgeon", or any other word or abbreviation that suggests that the optometrist practices medicine; or

(2) Any word or abbreviation that suggests that the optometrist treats diseases or injuries of the human eye, including the words "eye specialist", "eyesight specialist", "oculist", or "ophthalmologist".

11–404.

(a) Unless certified under this section, a licensed optometrist may not administer a topical ocular diagnostic pharmaceutical agent to a patient.

(b) The Board shall certify a licensed optometrist as qualified to administer topical ocular diagnostic pharmaceutical agents if the licensed optometrist submits to the Board evidence satisfactory to the Board that the licensed optometrist:

(1) Meets the educational requirements that the Board establishes for certification of qualification to administer topical ocular diagnostic pharmaceutical agents; and

(2) Has within 7 years before certification completed a course in pharmacology that meets the requirements of subsection (c) of this section.

(c) The course in pharmacology required by subsection (b) of this section shall:

(1) Be of at least the length that the Board establishes but not less than 70 course hours;

(2) Place emphasis on:

(i) Topical application of ocular diagnostic pharmaceutical agents for the purpose of examining and analyzing ocular functions; and

(ii) Allergic reactions to ocular diagnostic pharmaceutical agents; and

(3) Be given by an institution that is:

(i) Accredited by a regional or professional accrediting organization that is recognized or approved by the United States Commissioner of Education; and

(ii) Approved by the Board.

(d) The Board shall revoke the certification of qualification to administer topical ocular diagnostic pharmaceutical agents of any licensed optometrist who does not annually take a course of study, approved by the Board, that relates to the use of those agents.

~~(3)~~ (4) IF THE OPTOMETRIST IS CERTIFIED UNDER § 11–404 OF THIS SUBTITLE, USE THE TITLE "THERAPEUTICALLY CERTIFIED OPTOMETRIST".

(b) Except as otherwise provided in this section, a licensed optometrist may not attach to the optometrist's name or use as a title:

(1) The words or abbreviations "Doctor", "Dr.", "M.D.", "physician", or "surgeon", or any other word or abbreviation that suggests that the optometrist practices medicine; or

(2) Any word or abbreviation that suggests that the optometrist treats diseases or injuries of the human eye, including the words "eye specialist", "eyesight specialist", "oculist", or "ophthalmologist".

11–404.

(a) Unless certified under this section, a licensed optometrist may not administer a topical ocular diagnostic pharmaceutical agent to a patient.

(b) The Board shall certify a licensed optometrist as qualified to administer topical ocular diagnostic pharmaceutical agents if the licensed optometrist submits to the Board evidence satisfactory to the Board that the licensed optometrist:

(1) Meets the educational requirements that the Board establishes for certification of qualification to administer topical ocular diagnostic pharmaceutical agents; and

(2) Has within 7 years before certification completed a course in pharmacology that meets the requirements of subsection (c) of this section.

(c) The course in pharmacology required by subsection (b) of this section shall:

(1) Be of at least the length that the Board establishes but not less than 70 course hours;

(2) Place emphasis on:

(i) Topical application of ocular diagnostic pharmaceutical agents for the purpose of examining and analyzing ocular functions; and

(ii) Allergic reactions to ocular diagnostic pharmaceutical agents; and

(3) Be given by an institution that is:

(i) Accredited by a regional or professional accrediting organization that is recognized or approved by the United States Commissioner of Education; and

(ii) Approved by the Board.

(d) The Board shall revoke the certification of qualification to administer topical ocular diagnostic pharmaceutical agents of any licensed optometrist who does not annually take a course of study, approved by the Board, that relates to the use of those agents.

(e) Certification of qualification under this section authorizes the licensed optometrist who is certified under this section to administer a topical ocular diagnostic pharmaceutical agent to a patient for diagnostic purposes but not for purposes of treatment.

(f) Except as expressly authorized under this section for diagnostic purposes OR UNDER § 11–404.1 OF THIS SUBTITLE FOR THERAPEUTIC PURPOSES, an optometrist may not administer drugs or medicine to any patient.

(g) The Department shall collect and report statistical information on the incidences of negative reactions to the administration by optometrists of topical ocular diagnostic pharmaceutical agents.

11–404.1.

(A) UNLESS CERTIFIED UNDER THIS SECTION, A LICENSED OPTOMETRIST MAY NOT ADMINISTER OR PRESCRIBE ANY THERAPEUTIC PHARMACEUTICAL AGENTS OR REMOVE SUPERFICIAL FOREIGN BODIES FROM A HUMAN EYE ~~OR ADNEXA~~, ADNEXA, OR LACRIMAL SYSTEM.

(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THE BOARD SHALL CERTIFY A LICENSED OPTOMETRIST AS ~~QUALIFIED TO ADMINISTER AND PRESCRIBE THERAPEUTIC PHARMACEUTICAL AGENTS AND TO REMOVE SUPERFICIAL FOREIGN BODIES FROM THE HUMAN EYE OR ADNEXA~~ A THERAPEUTICALLY CERTIFIED OPTOMETRIST IF THE LICENSED OPTOMETRIST SUBMITS TO THE BOARD EVIDENCE SATISFACTORY TO THE BOARD THAT THE LICENSED OPTOMETRIST:

~~(1)~~ (I) HAS SUCCESSFULLY COMPLETED AT LEAST 110 HOURS OF A THERAPEUTIC PHARMACEUTICAL AGENTS COURSE APPROVED BY THE BOARD; ~~EXCEPT THAT AN OPTOMETRIST WHO HAS GRADUATED FROM AN ACCREDITED SCHOOL OF OPTOMETRY RECOGNIZED BY THE BOARD ON OR AFTER JULY 1, 1992 MAY NOT BE SUBJECT TO THE REQUIREMENT OF THIS PARAGRAPH;~~

~~(2)~~ (II) HAS SUCCESSFULLY PASSED A PHARMACOLOGY EXAMINATION:

~~(I)~~ RELATING TO THE TREATMENT AND MANAGEMENT OF OCULAR DISEASE, WHICH IS PREPARED, ADMINISTERED, AND GRADED BY THE NATIONAL BOARD OF EXAMINERS IN OPTOMETRY OR ANY OTHER NATIONALLY RECOGNIZED OPTOMETRIC ORGANIZATION AS APPROVED BY THE SECRETARY; ~~OR~~ AND

~~(II) THAT IS EQUIVALENT TO THE EXAMINATION DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH, WHICH IS PREPARED, ADMINISTERED, AND GRADED BY A PROFESSIONALLY QUALIFIED TESTING ORGANIZATION RECOGNIZED BY THE BOARD; AND~~

~~(3)~~ (III) IS CURRENTLY CERTIFIED BY THE BOARD TO ADMINISTER TOPICAL OCULAR DIAGNOSTIC PHARMACEUTICAL AGENTS UNDER § 11–404 OF THIS SUBTITLE.

(2) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, AN OPTOMETRIST WHO HAS GRADUATED ON OR AFTER JULY 1, 1992 FROM AN ACCREDITED SCHOOL OF OPTOMETRY RECOGNIZED BY THE BOARD IS NOT SUBJECT TO THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION.

(II) IF AN OPTOMETRIST WHO HAS GRADUATED ON OR AFTER JULY 1, 1992 FROM AN ACCREDITED SCHOOL OF OPTOMETRY RECOGNIZED BY THE BOARD IS NOT CERTIFIED UNDER THIS SECTION WITHIN 3 YEARS OF GRADUATION, THE OPTOMETRIST SHALL SUCCESSFULLY COMPLETE A THERAPEUTIC PHARMACEUTICAL AGENTS COURSE AND SUCCESSFULLY PASS A PHARMACOLOGY EXAM UNDER PARAGRAPH (1) OF THIS SUBSECTION BEFORE THE BOARD MAY CERTIFY THE OPTOMETRIST.

~~(C) IN ADDITION TO THE REQUIREMENTS SET FORTH IN § 11-309 OF THIS TITLE, A THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL COMPLETE A MINIMUM OF 6 HOURS OF BOARD APPROVED CONTINUING EDUCATION IN THE FIELD OF PHARMACOLOGY RELATING TO THE TREATMENT AND MANAGEMENT OF OCULAR DISEASE DURING EACH LICENSING PERIOD.~~

~~(D) CERTIFICATION UNDER THIS SECTION AUTHORIZES THE THERAPEUTICALLY CERTIFIED OPTOMETRIST TO:~~

~~(1) ADMINISTER AND PRESCRIBE TOPICAL AND ORAL PHARMACEUTICAL AGENTS RATIONAL TO THE DIAGNOSIS AND TREATMENT OF CONDITIONS AND DISEASES OF THE HUMAN EYE AND ADNEXA;~~

~~(2) REMOVE SUPERFICIAL FOREIGN BODIES FROM THE HUMAN EYE AND ADNEXA;~~

~~(3) PERFORM PROCEDURES RATIONAL TO THE TREATMENT OF CONDITIONS AND DISEASES OF THE HUMAN EYE AND ADNEXA AS DETERMINED BY THE BOARD;~~

~~(4) PERFORM OR ORDER PROCEDURES AND LABORATORY TESTS RATIONAL TO THE DIAGNOSIS AND TREATMENT OF CONDITIONS AND DISEASES OF THE HUMAN EYE AND ADNEXA; AND~~

~~(5) DISPENSE A THERAPEUTIC PHARMACEUTICAL AGENT TO A PATIENT IF:~~

~~(I) NO CHARGE IS IMPOSED FOR THE THERAPEUTIC PHARMACEUTICAL AGENT OR FOR DISPENSING THE AGENT; AND~~

~~(II) THE AMOUNT DISPENSED DOES NOT EXCEED A 72-HOUR SUPPLY, EXCEPT THAT IF THE MINIMUM AVAILABLE QUANTITY FOR DISPENSING IS GREATER THAN A 72-HOUR SUPPLY, THE MINIMUM AVAILABLE QUANTITY MAY BE DISPENSED.~~

~~(E) UNLESS OTHERWISE AUTHORIZED UNDER THIS TITLE, AN OPTOMETRIST PRACTICING IN THE STATE MAY NOT:~~

~~(1) USE SURGICAL OPHTHALMIC LASERS;~~

(2) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, AN OPTOMETRIST WHO HAS GRADUATED ON OR AFTER JULY 1, 1992 FROM AN ACCREDITED SCHOOL OF OPTOMETRY RECOGNIZED BY THE BOARD IS NOT SUBJECT TO THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION.

(II) IF AN OPTOMETRIST WHO HAS GRADUATED ON OR AFTER JULY 1, 1992 FROM AN ACCREDITED SCHOOL OF OPTOMETRY RECOGNIZED BY THE BOARD IS NOT CERTIFIED UNDER THIS SECTION WITHIN 3 YEARS OF GRADUATION, THE OPTOMETRIST SHALL SUCCESSFULLY COMPLETE A THERAPEUTIC PHARMACEUTICAL AGENTS COURSE AND SUCCESSFULLY PASS A PHARMACOLOGY EXAM UNDER PARAGRAPH (1) OF THIS SUBSECTION BEFORE THE BOARD MAY CERTIFY THE OPTOMETRIST.

~~(C) IN ADDITION TO THE REQUIREMENTS SET FORTH IN § 11-309 OF THIS TITLE, A THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL COMPLETE A MINIMUM OF 6 HOURS OF BOARD APPROVED CONTINUING EDUCATION IN THE FIELD OF PHARMACOLOGY RELATING TO THE TREATMENT AND MANAGEMENT OF OCULAR DISEASE DURING EACH LICENSING PERIOD.~~

~~(D) CERTIFICATION UNDER THIS SECTION AUTHORIZES THE THERAPEUTICALLY CERTIFIED OPTOMETRIST TO:~~

~~(1) ADMINISTER AND PRESCRIBE TOPICAL AND ORAL PHARMACEUTICAL AGENTS RATIONAL TO THE DIAGNOSIS AND TREATMENT OF CONDITIONS AND DISEASES OF THE HUMAN EYE AND ADNEXA;~~

~~(2) REMOVE SUPERFICIAL FOREIGN BODIES FROM THE HUMAN EYE AND ADNEXA;~~

~~(3) PERFORM PROCEDURES RATIONAL TO THE TREATMENT OF CONDITIONS AND DISEASES OF THE HUMAN EYE AND ADNEXA AS DETERMINED BY THE BOARD;~~

~~(4) PERFORM OR ORDER PROCEDURES AND LABORATORY TESTS RATIONAL TO THE DIAGNOSIS AND TREATMENT OF CONDITIONS AND DISEASES OF THE HUMAN EYE AND ADNEXA; AND~~

~~(5) DISPENSE A THERAPEUTIC PHARMACEUTICAL AGENT TO A PATIENT IF:~~

~~(I) NO CHARGE IS IMPOSED FOR THE THERAPEUTIC PHARMACEUTICAL AGENT OR FOR DISPENSING THE AGENT; AND~~

~~(II) THE AMOUNT DISPENSED DOES NOT EXCEED A 72-HOUR SUPPLY, EXCEPT THAT IF THE MINIMUM AVAILABLE QUANTITY FOR DISPENSING IS GREATER THAN A 72-HOUR SUPPLY, THE MINIMUM AVAILABLE QUANTITY MAY BE DISPENSED.~~

~~(E) UNLESS OTHERWISE AUTHORIZED UNDER THIS TITLE, AN OPTOMETRIST PRACTICING IN THE STATE MAY NOT:~~

~~(1) USE SURGICAL OPHTHALMIC LASERS;~~

~~(2) PERFORM CATARACT SURGERY OR ANY OTHER SURGERY;~~

~~(3) PERFORM RADIAL KERATOTOMY; OR~~

~~(4) DISPENSE A THERAPEUTIC PHARMACEUTICAL AGENT TO ANY PERSON.~~

~~(F) A THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL BE HELD TO THE SAME STANDARD OF CARE APPLIED TO A PHYSICIAN LICENSED UNDER TITLE 14 OF THIS ARTICLE PROVIDING SIMILAR SERVICES.~~

11–404.2.

(A) IN THIS SECTION, "REFER" MEANS THAT A THERAPEUTICALLY CERTIFIED OPTOMETRIST:

(1) INFORMS THE PATIENT THAT THE PATIENT SHOULD SEE AN OPHTHALMOLOGIST AND GIVE THE OPHTHALMOLOGIST AN OPPORTUNITY TO PHYSICALLY EXAMINE THE PATIENT; AND

(2) REFRAINS FROM RENDERING FURTHER TREATMENT FOR THE SPECIFIC CONDITION THAT IS THE BASIS FOR THE REFERRAL UNTIL THE PATIENT HAS BEEN PHYSICALLY EXAMINED BY AN OPHTHALMOLOGIST.

(B) (1) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY ADMINISTER AND PRESCRIBE TOPICAL THERAPEUTIC PHARMACEUTICAL AGENTS LIMITED TO:

(I) OCULAR ANTIHISTAMINES, DECONGESTANTS, AND COMBINATIONS THEREOF, EXCLUDING STEROIDS;

(II) OCULAR ANTIALLERGY PHARMACEUTICAL AGENTS;

(III) OCULAR ANTIBIOTICS AND COMBINATIONS OF OCULAR ANTIBIOTICS, EXCLUDING SPECIALLY FORMULATED OR FORTIFIED ANTIBIOTICS;

(IV) ANTIINFLAMMATORY AGENTS, EXCLUDING STEROIDS;

(V) OCULAR LUBRICANTS AND ARTIFICIAL TEARS;

(VI) TROPICAMIDE;

(VII) HOMATROPINE;

(VIII) NONPRESCRIPTION DRUGS THAT ARE COMMERCIALLY AVAILABLE; AND

(IX) PRIMARY OPEN-ANGLE GLAUCOMA MEDICATIONS, IN ACCORDANCE WITH SUBSECTION (C) OF THIS SECTION.

(2) IF A THERAPEUTICALLY CERTIFIED OPTOMETRIST ADMINISTERS OR PRESCRIBES A TOPICAL THERAPEUTIC PHARMACEUTICAL AGENT LISTED IN PARAGRAPH (1)(I) THROUGH (VII) OF THIS SUBSECTION, AND THE PATIENT DOES NOT HAVE THE EXPECTED RESPONSE WITHIN 72 HOURS:

(I) THE THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL CONSULT WITH AN OPHTHALMOLOGIST; AND

(II) THE OPHTHALMOLOGIST MAY DETERMINE THAT THE OPHTHALMOLOGIST NEEDS TO PHYSICALLY EXAMINE THE PATIENT.

(3) IF A THERAPEUTICALLY CERTIFIED OPTOMETRIST ADMINISTERS OR PRESCRIBES A TOPICAL THERAPEUTIC PHARMACEUTICAL AGENT UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL COMMUNICATE WITH THE PATIENT TO DETERMINE THE RESPONSE OF THE PATIENT TO THE THERAPEUTIC PHARMACEUTICAL AGENT AS SOON AS PRACTICABLE AFTER 72 HOURS OF THE TIME THE AGENT WAS ADMINISTERED OR PRESCRIBED.

(4) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY NOT ADMINISTER OR PRESCRIBE:

(I) STEROIDS;

(II) ANTIVIRAL AGENTS;

(III) ANTIFUNGAL AGENTS;

(IV) ANTIMETABOLITE AGENTS; OR

(V) ANTIPARASITIC AGENTS.

(5) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY DISPENSE A TOPICAL THERAPEUTIC PHARMACEUTICAL AGENT LISTED IN PARAGRAPH (1) OF THIS SUBSECTION ONLY IF:

(I) NO CHARGE IS IMPOSED FOR THE THERAPEUTIC PHARMACEUTICAL AGENT OR FOR DISPENSING THE AGENT; AND

(II) THE AMOUNT DISPENSED DOES NOT EXCEED A 72-HOUR SUPPLY, EXCEPT THAT IF THE MINIMUM AVAILABLE QUANTITY FOR DISPENSING IS GREATER THAN A 72-HOUR SUPPLY, THE MINIMUM AVAILABLE QUANTITY MAY BE DISPENSED.

(C) (1) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY ADMINISTER AND PRESCRIBE TOPICAL THERAPEUTIC PHARMACEUTICAL AGENTS FOR GLAUCOMA ONLY:

(I) FOR PATIENTS WITH PRIMARY OPEN-ANGLE GLAUCOMA;

(II) AFTER THE OPTOMETRIST REFERS THE PATIENT TO AN OPHTHALMOLOGIST; AND

(III) AFTER THE OPHTHALMOLOGIST AND OPTOMETRIST JOINTLY AND PROMPTLY DEVELOP A WRITTEN INDIVIDUALIZED TREATMENT PLAN THAT IS SIGNED BY THE OPHTHALMOLOGIST AND OPTOMETRIST AND INCLUDES:

1. ALL TESTS AND EXAMINATIONS THAT LED TO THE DIAGNOSIS;

(I) THE THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL CONSULT WITH AN OPHTHALMOLOGIST; AND

(II) THE OPHTHALMOLOGIST MAY DETERMINE THAT THE OPHTHALMOLOGIST NEEDS TO PHYSICALLY EXAMINE THE PATIENT.

(3) IF A THERAPEUTICALLY CERTIFIED OPTOMETRIST ADMINISTERS OR PRESCRIBES A TOPICAL THERAPEUTIC PHARMACEUTICAL AGENT UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL COMMUNICATE WITH THE PATIENT TO DETERMINE THE RESPONSE OF THE PATIENT TO THE THERAPEUTIC PHARMACEUTICAL AGENT AS SOON AS PRACTICABLE AFTER 72 HOURS OF THE TIME THE AGENT WAS ADMINISTERED OR PRESCRIBED.

(4) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY NOT ADMINISTER OR PRESCRIBE:

(I) STEROIDS;

(II) ANTIVIRAL AGENTS;

(III) ANTIFUNGAL AGENTS;

(IV) ANTIMETABOLITE AGENTS; OR

(V) ANTIPARASITIC AGENTS.

(5) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY DISPENSE A TOPICAL THERAPEUTIC PHARMACEUTICAL AGENT LISTED IN PARAGRAPH (1) OF THIS SUBSECTION ONLY IF:

(I) NO CHARGE IS IMPOSED FOR THE THERAPEUTIC PHARMACEUTICAL AGENT OR FOR DISPENSING THE AGENT; AND

(II) THE AMOUNT DISPENSED DOES NOT EXCEED A 72-HOUR SUPPLY, EXCEPT THAT IF THE MINIMUM AVAILABLE QUANTITY FOR DISPENSING IS GREATER THAN A 72-HOUR SUPPLY, THE MINIMUM AVAILABLE QUANTITY MAY BE DISPENSED.

(C) (1) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY ADMINISTER AND PRESCRIBE TOPICAL THERAPEUTIC PHARMACEUTICAL AGENTS FOR GLAUCOMA ONLY:

(I) FOR PATIENTS WITH PRIMARY OPEN-ANGLE GLAUCOMA;

(II) AFTER THE OPTOMETRIST REFERS THE PATIENT TO AN OPHTHALMOLOGIST; AND

(III) AFTER THE OPHTHALMOLOGIST AND OPTOMETRIST JOINTLY AND PROMPTLY DEVELOP A WRITTEN INDIVIDUALIZED TREATMENT PLAN THAT IS SIGNED BY THE OPHTHALMOLOGIST AND OPTOMETRIST AND INCLUDES:

1. ALL TESTS AND EXAMINATIONS THAT LED TO THE DIAGNOSIS;

2. AN INITIAL SCHEDULE OF ALL TESTS AND EXAMINATIONS NECESSARY TO TREAT THE PATIENT'S CONDITION;

3. A MEDICATION PLAN;

4. A TARGET INTRAOCULAR PRESSURE; AND

5. CRITERIA FOR SURGICAL INTERVENTION BY THE OPHTHALMOLOGIST.

(2) (I) A TREATMENT PLAN DEVELOPED UNDER THIS SUBSECTION MAY BE MODIFIED ONLY AFTER BOTH THE OPTOMETRIST AND THE OPHTHALMOLOGIST CONSULT TOGETHER AND CONSENT TO THE MODIFICATION.

(II) EACH MODIFICATION SHALL BE NOTED IN THE OPTOMETRIC RECORD OF THE PATIENT.

(3) A THERAPEUTICALLY CERTIFIED OPTOMETRIST WHO TREATS A PATIENT WITH PRIMARY OPEN-ANGLE GLAUCOMA IN ACCORDANCE WITH THIS SECTION:

(I) SHALL REFER THE PATIENT TO AN OPHTHALMOLOGIST AT LEAST ONCE A YEAR AFTER THE INITIAL MANDATORY REFERRAL UNDER PARAGRAPH (1) OF THIS SUBSECTION;

(II) MAY CONTINUE TO RENDER TREATMENT UNDER THE JOINT TREATMENT PLAN UNTIL THE PATIENT IS EXAMINED BY AN OPHTHALMOLOGIST;

(III) SHALL CONSULT WITH AN OPHTHALMOLOGIST IF:

1. THE PATIENT DOES NOT HAVE THE EXPECTED RESPONSE TO TREATMENT;

2. THE TARGET INTRAOCULAR PRESSURE IS NOT REACHED; OR

3. THERE IS WORSENING IN A PATIENT'S VISUAL FIELD OR OPTIC NERVE HEAD; AND

(IV) MAY PERFORM AND EVALUATE VISUAL FIELD TESTS, NERVE FIBER LAYER PHOTOS, AND OPTIC DISC PHOTOS. THE TESTS OR PHOTOS SHALL BE PROVIDED TO AN OPHTHALMOLOGIST FOR REVIEW BY THE OPHTHALMOLOGIST.

(D) (1) EXCEPT AS PROVIDED IN PARAGRAPHS (2) AND (3) OF THIS SUBSECTION, A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY NOT ADMINISTER OR PRESCRIBE ANY ORAL PHARMACEUTICAL AGENT FOR ANY PURPOSE.

(2) (I) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY ADMINISTER AND PRESCRIBE ORAL TETRACYCLINE AND ITS DERIVATIVES ONLY FOR THE DIAGNOSIS AND TREATMENT OF MEIBOMITIS AND SEBORRHEIC BLEPHARITIS.

(II) IF A THERAPEUTICALLY CERTIFIED OPTOMETRIST ADMINISTERS OR PRESCRIBES ORAL TETRACYCLINE OR ITS DERIVATIVES TO A PATIENT IN ACCORDANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH AND THE PATIENT DOES NOT IMPROVE WITHIN 3 WEEKS OF TREATMENT, THE OPTOMETRIST SHALL REFER THE PATIENT TO AN OPHTHALMOLOGIST.

(3) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY ADMINISTER OR PRESCRIBE NONPRESCRIPTION DRUGS THAT ARE COMMERCIALLY AVAILABLE.

(E) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY NOT PERFORM ANY PROCEDURE ON THE EYELID OF A PATIENT.

(2) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY EPILATE WITH FORCEPS AN EYELASH FROM THE EYELID, ADNEXA, OR LACRIMAL SYSTEM OF A PATIENT.

(F) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY REMOVE SUPERFICIAL FOREIGN BODIES FROM THE HUMAN EYE ONLY IF:

(1) THE FOREIGN BODY MAY BE REMOVED WITH A COTTON-TIPPED APPLICATOR OR BLUNT SPATULA; AND

(2) THE FOREIGN BODY HAS NOT PENETRATED BEYOND THE BOWMAN'S MEMBRANE OF THE CORNEA AND IS NOT WITHIN 2.5 MILLIMETERS OF THE VISUAL AXIS.

(G) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY NOT ORDER LABORATORY TESTS FOR A PATIENT.

(2) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY ORDER A CONJUNCTIVAL CULTURE.

(H) A THERAPEUTICALLY CERTIFIED OPTOMETRIST MAY NOT PROVIDE ANY THERAPEUTIC TREATMENT LISTED IN THIS SECTION FOR A CHILD UNDER THE AGE OF 1 YEAR.

(I) UNLESS THE STANDARD OF CARE REQUIRES AN EARLIER REFERRAL, IF A THERAPEUTICALLY CERTIFIED OPTOMETRIST DIAGNOSES A CORNEAL ULCER OR INFILTRATE, AND THE PATIENT DOES NOT HAVE THE EXPECTED RESPONSE WITHIN 48 HOURS, THE OPTOMETRIST IMMEDIATELY SHALL REFER THE PATIENT TO AN OPHTHALMOLOGIST.

(J) A THERAPEUTICALLY CERTIFIED OPTOMETRIST SHALL BE HELD TO THE SAME STANDARD OF CARE AS AN OPHTHALMOLOGIST WHO IS LICENSED UNDER TITLE 14 OF THIS ARTICLE AND WHO IS PROVIDING SIMILAR SERVICES.

11–404.3.

(A) THE MARYLAND OPTOMETRIC ASSOCIATION AND THE MARYLAND SOCIETY OF EYE PHYSICIANS AND SURGEONS SHALL RECOMMEND TO THE

(II) IF A THERAPEUTICALLY CERTIFIED OPTOMETRIST ADMINISTERS OR PRESCRIBES ORAL TETRACYCLINE OR ITS DERIVATIVES TO A PATIENT IN ACCORDANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH AND THE PATIENT DOES NOT IMPROVE WITHIN 3 WEEKS OF TREATMENT, THE OPTOMETRIST SHALL REFER THE PATIENT TO AN OPHTHALMOLOGIST.

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11–404.3.

(A) THE MARYLAND OPTOMETRIC ASSOCIATION AND THE MARYLAND SOCIETY OF EYE PHYSICIANS AND SURGEONS SHALL RECOMMEND TO THE

SECRETARY QUALITY ASSURANCE GUIDELINES FOR THERAPEUTICALLY CERTIFIED OPTOMETRISTS AND OPTOMETRIC CARE.

(B) (1) AFTER CONSIDERING THE RECOMMENDATIONS OF THE MARYLAND OPTOMETRIC ASSOCIATION AND THE MARYLAND SOCIETY OF EYE PHYSICIANS AND SURGEONS, THE SECRETARY SHALL ADOPT REGULATIONS THAT ESTABLISH:

(I) STANDARDS OF QUALITY FOR THERAPEUTICALLY CERTIFIED OPTOMETRISTS AND OPTOMETRIC CARE;

(II) AN ONGOING QUALITY ASSURANCE PROGRAM THAT INCLUDES THE MONITORING AND STUDY OF THE JOINT MANAGEMENT OF PRIMARY OPEN-ANGLE GLAUCOMA PATIENTS UNDER § 11-404.2(C) OF THIS SUBTITLE;

(III) A PROGRAM TO EVALUATE THE COST OF OPTOMETRIC CARE; AND

(IV) A PLAN TO MONITOR COMPLAINT INVESTIGATION.

(2) THE REGULATIONS SHALL REQUIRE THE BOARD TO:

(I) CONDUCT A CONTINUING STUDY AND INVESTIGATION OF THERAPEUTICALLY CERTIFIED OPTOMETRISTS TO ENSURE THE QUALITY OF CARE THEY PROVIDE; AND

(II) REPORT TO THE SECRETARY, AS THE SECRETARY REQUIRES, ON THE RESULTS OF THE BOARD'S STUDY AND INVESTIGATION.

(3) THE BOARD'S STUDY AND INVESTIGATION SHALL INCLUDE:

(I) A PEER REVIEW PROGRAM; AND

(II) A REVIEW OF PATIENT OPTOMETRIC RECORDS THAT INCLUDES THE COLLECTION AND EVALUATION OF DATA ON THE DRUGS BEING PRESCRIBED AND ADMINISTERED AND THE APPROPRIATENESS OF TREATMENT BY THERAPEUTICALLY CERTIFIED OPTOMETRISTS.

11-503.

AN OPTOMETRIST PRACTICING IN THE STATE MAY NOT:

(1) USE SURGICAL LASERS;

(2) PERFORM ANY SURGERY, INCLUDING CATARACT SURGERY OR CRYOSURGERY;

(3) PERFORM A RADIAL KERATOTOMY;

(4) GIVE AN INJECTION, EXCEPT THAT AN OPTOMETRIST MAY GIVE AN INJECTION OF EPINEPHRINE IN THE APPROPRIATE DOSE FOR THE TREATMENT OF ACUTE ANAPHYLAXIS OR EMERGENCY RESUSCITATION; OR

(5) EXCEPT AS PROVIDED UNDER THIS TITLE, DISPENSE A THERAPEUTIC PHARMACEUTICAL AGENT TO ANY PERSON.

SECTION 2. AND BE IT FURTHER ENACTED, That, as of the effective date of this Act, the only therapeutic pharmaceutical agents course that is approved by the Secretary of Health and Mental Hygiene is given by the State University of New York (SUNY) College of Optometry.

SECTION 3. AND BE IT FURTHER ENACTED, That nothing in this Act may be construed to limit the scope of the practice of ophthalmology, or to impose any potential liability on an ophthalmologist beyond that already imposed by the standard of care.

SECTION 4. AND BE IT FURTHER ENACTED, That the Secretary of the Department of Health and Mental Hygiene, in conjunction with the State Board of Examiners in Optometry, shall report to the General Assembly on December 15, 1999, in accordance with § 2–1312 of the State Government Article, on the implementation of this Act. The report shall include a recommendation as to whether the co–management of primary open–angle glaucoma patients by ophthalmologists and therapeutically certified optometrists should be terminated, continued, or modified, and shall be based on the data collected by the Board under the Quality Assurance Program.

SECTION 5. AND BE IT FURTHER ENACTED, That if any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of this Act which can be given effect without the invalid provision or application, and for this purpose the provisions of this Act are declared severable.

SECTION ~~2.~~ 6. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1995.

Approved:

_____

Governor.

_____

President of the Senate.

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Speaker of the House of Delegates.

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Speaker of the House of Delegates.

1997 SESSION

Medical Practice Act

ENROLLED

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend the Code of Virginia by adding a section numbered 54.1-2400.01, relating to the definition of laser surgery.

[S 1174]

Approved

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2400.01 as follows:

§ 54.1-2400.01. Certain definition.

As used in this subtitle, "Laser surgery" means treatment through revision, destruction, incision or other structural alteration of human tissue using laser technology. Under this definition, the continued use of laser technology solely for nonsurgical purposes of examination and diagnosis shall be permitted for those professions whose licenses permit such use.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor

STATE STATUTORY RESTRICTIONS
OPTOMETRIC STATUTES

Of the 52 states, including the District of Columbia and Puerto Rico, therapeutic bills have been passed in 49 states. All of these states have restrictions on the scope of practice of optometry in statute or in regulation. The restrictions preserve components of medical eye care for patients. Some of those restrictions include:

49 States	Prohibit surgery by optometrists.
36 States	Prohibit laser surgery by optometrists.
31 States	Require referral, or collaboration, to an ophthalmologist or physician.
31 States	Prohibit glaucoma treatment completely, or restrict through referral or collaboration requirements.
20 States	Prohibit oral medications. Only topical drugs are allowed.
16 States	Prohibit steroid medications.
12 States	Prohibit the use of injections.
9 States	Prohibit the removal of foreign bodies from the eye.

Note: State statutes do not specifically address each of these provisions, however that does not mean that optometrists are permitted to perform certain procedures.

May 22, 1997

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May 22, 1997

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A-1
May 22, 1997

OPTOMETRIC SCOPE OF PRACTICE
STATUTORY RESTRICTIONS

State	Oral Medication Not Allowed	Steroids Restricted	Referral or Collaboration Required	Foreign Body Removal Not Allowed	Glaucoma Treatment Restricted	Standard of Care Required	Surgery Prohibited	Therapeutics With Restrictions
Alabama							X	X
Alaska	X						X	X
Arizona	X	X	X				X	X
Arkansas							X	X
California	X[1]	X	X		X	X	X	X
Colorado			X		X	X	X	X
Connecticut			X		X	X	X	X
Delaware						X	X	X
Dist of Columbia	X	X	X	X	X			
Florida	X		X		X	X	X	X
Georgia			X	X	X	X	X	X
Hawaii	X		X		X		X	X
Idaho							X	X
Illinois	X[2]		X				X	X
Indiana			X		X		X	X
Iowa						X	X	X
Kansas	X		X		X	X	X	X
Kentucky							X	X
Louisiana				X			X	X
Maine					X[3]	X	X	X
Maryland	X[4]	X	X		X	X	X	X
Massachusetts	X	X	X	X	X			
Michigan	X		X		X		X	X
Minnesota	X		X	X		X	X	X

[1] Topicals except for oral tetracycline.

[2] Topicals except for non-narcotic oral analgesic agents.

[3] Consultation and referral required during co-management training.

[4] Topicals except for oral tetracycline.

State	Oral Medication Not Allowed	Steroids Restricted	Referral or Collaboration Required	Foreign Body Removal Not Allowed	Glaucoma Treatment Restricted	Standard of Care Required	Surgery Prohibited	Therapeutics With Restrictions
Mississippi	X		X			X	X	X
Missouri			X			X	X	X
Montana					X		X	X
Nebraska		X			X	X	X	X
Nevada					X		X	X
New Hampshire		X			X		X	X
New Jersey						X		X
New Mexico		X					X	X
New York	X	X	X		X	X	X	X
North Carolina			X		X		X	X
North Dakota			X		X	X	X	X
Ohio				X			X	X
Oklahoma								X
Oregon	X	X	X		X	X	X	X
Pennsylvania	X	X	X		X		X	X
Puerto Rico	X	X		X	X		X	
Rhode Island	X		X		X		X	X
South Carolina		X	X		X	X	X	X
South Dakota			X		X		X	X
Tennessee				X		X	X	X
Texas		X	X		X	X	X	X
Utah			X				X	X
Vermont	X	X	X		X	X	X	X
Virginia			X		X		X	X
Washington	X			X				X
West Virginia							X	X
Wisconsin			X		X		X	X
Wyoming		X	X		X	X	X	X
TOTALS	20	16	31	9	31	23	47	49

State	Oral Medication Not Allowed	Steroids Restricted	Referral or Collaboration Required	Foreign Body Removal Not Allowed	Glaucoma Treatment Restricted	Standard of Care Required	Surgery Prohibited	Therapeutics With Restrictions
Mississippi	X		X			X	X	X
Missouri			X			X	X	X
Montana					X		X	X
Nebraska		X			X	X	X	X
Nevada					X		X	X
New Hampshire		X			X		X	X
New Jersey						X		X
New Mexico		X					X	X
New York	X	X	X		X	X	X	X
North Carolina			X		X		X	X
North Dakota			X		X	X	X	X
Ohio				X			X	X
Oklahoma								X
Oregon	X	X	X		X	X	X	X
Pennsylvania	X	X	X		X		X	X
Puerto Rico	X	X		X	X		X	
Rhode Island	X		X		X		X	X
South Carolina		X	X		X	X	X	X
South Dakota			X		X		X	X
Tennessee				X		X	X	X
Texas		X	X		X	X	X	X
Utah			X				X	X
Vermont	X	X	X		X	X	X	X
Virginia			X		X		X	X
Washington	X			X				X
West Virginia							X	X
Wisconsin			X		X		X	X
Wyoming		X	X		X	X	X	X
TOTALS	20	16	31	9	31	23	47	49

NOTES:

Language in the statutes does not always reflect the drugs listed in formularies. Detailed listings of the provisions in each state are available through the American Academy of Ophthalmology State Affairs Department. Other points of note are:

- Although surgery is prohibited in 47 states, this does not necessarily mean that lasers are specifically prohibited or that a definition of surgery is included.

  The use of lasers is prohibited in 36 states. Connecticut, Delaware, Georgia, Michigan, Tennessee, and Wyoming prohibit the use of therapeutic lasers but do not specifically prohibit the use of diagnostic lasers. California and Vermont specifically allow the use of diagnostic lasers. Kentucky optometrists are not allowed to do laser surgery, though it is not stated in the statute. Indiana, Louisiana and Minnesota prohibit surgery and the use of lasers in the medical practice acts. Virginia prohibits laser surgery in optometric statute and the medical practice act. Idaho prohibits use of lasers and upholds legal ruling prohibiting surgery and laser surgery.

  None of the 50 states, the District of Columbia, or Puerto Rico allow optometrists to perform surgery, even though it is not specifically written in all statutes. In Idaho and Oklahoma optometry boards interpreted silent statutes as permitting optometrists to perform laser surgery.

- In 3 states, (including the District of Columbia and Puerto Rico) optometrists are restricted to the use of diagnostic drugs only. The following drugs are not permitted in diagnostic states: antibiotics, antihistamines, anti-inflammatories, glaucoma and steroid drugs. Of these 3 states, Puerto Rico does not contain a statutory prohibition for optometrists making a diagnosis. The remaining 2 states do not permit optometrists to make a diagnosis, but require optometrists to refer the patient to a physician for diagnosis and treatment.

  All 50 states and the District of Columbia permit optometrists to use diagnostic pharmaceutical agents. Puerto Rico does not permit the use of diagnostic drugs.

- Therapeutic states allow the use of topical antibiotics, antihistamines and anti-inflammatory and non-steroid anti-inflammatory drugs, even if the drugs are not always listed in the statutes. Non-steroid anti-inflammatories and steroids can be used in treating the same conditions.

- Arkansas, Alabama, Connecticut, Louisiana, Missouri, Tennessee and Utah include optometrists as providers for clinical laboratory testing. California allows ordering of smears and cultures within scope.

- Georgia and South Carolina require optometrists to carry $1 million of malpractice insurance; Colorado requires $1.5 million; and Pennsylvania requires $600,000. Kansas board determines acceptable amount of professional liability insurance.

- Mississippi allows postophthalmic surgical or clinical care and management with advice and consultation of operating or treating physician.

- Oklahoma prohibits the use of Schedules I and II drugs for purposes of diagnosis and treatment of ocular abnormalities.

- The non-restrictive language in the optometric statutes in Oklahoma, Idaho and Tennessee, have prompted optometry to broadly interpret these statutes being especially permissive TPA laws.

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DHRM

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OPTOMETRIC CONSULTANT
9704 FRANK TIPPETT ROAD
UPPER MARLBORO, MD 20772-4562
TELEPHONE: (301) 868-9428

MAY 22, 1997

COUNCILMEMBER HAROLD BRAZIL (CHAIR)
1350 PENNSYLVANIA AVENUE, NW, ROOM 110
WASHINGTON, DC 20004

DEAR COUNCILMEMBER BRAZIL:

THIS LETTER IS TO REQUEST YOUR SUPPORT OF BILL #12-152 "DEFINITION OF OPTOMETRY AMENDMENT ACT OF 1997." A PUBLIC HEARING HAS BEEN SCHEDULED FOR MAY 28, 1997. THIS BILL PERMITS DOCTORS OF OPTOMETRY TO PRESCRIBE THERAPEUTIC PHARMACEUTICAL AGENTS TO TREAT CERTAIN EYE DISEASES. THE BILL WILL BE A TREMENDOUS BENEFIT TO THE CITIZENS OF THE DISTRICT OF COLUMBIA.

PRESENTLY, LEGISLATION HAS BEEN PASSED IN 49 STATES ALLOWING OPTOMETRISTS TO PRESCRIBE THESE MEDICATIONS. BOTH MARYLAND AND VIRGINIA OPTOMETRISTS ARE PRESCRIBING THERAPEUTIC MEDICATIONS.

YOUR SUPPORT WOULD BE GREATLY APPRECIATED.

SINCERELY,

Ernest P. Daniels

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DHHM

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ERNEST P. DANIELS, O.D.

STEPHEN L GLASSER, OD, PC

May 19, 1997

MAY 20

Councilmember Brazil
1350 Pennsylvania Avenue, Room 110
Washington, DC 20004

Dear Councilmember Brazil,

I am writing to you, as both a practitioner and your optometrist, to request your support of Bill #12-152, the "Definition of Optometry Amendment Act of 1997". This bill permits Doctors of Optometry to prescribe therapeutic agents to treat infections and diseases of the eye.

All of the states (with the exception of Massachusetts) have already passed such a bill. I would hate to see the District of Columbia be the last "state" to pass such a provision.

This bill will be a tremendous benefit to the citizens of the District. It will result in a more cost efficient, convenient and quicker method of care.

Optometrists examine the majority of the District's citizens for eye care. The bill would allow the patient to see one practitioner for his or her vision and eye care, rather than seeing two, as is presently required. This would save the citizens and the District, particularly under its Medicaid system, a huge amount of expense will still maintaining the highest quality of care available.

In addition, this bill would put the District on par with other states. At the present time, it is difficult to attract new and leading practitioners here because of the limited scope of optometry. With the passage of the bill, we would be able to have the best and brightest in the field consider DC as their home and place of practice.

With these in mind, I urge you to support the passage of Bill #12-152, for which a public hearing has been scheduled on May 28, 1997. The citizens of the District deserve no less.

Sincerely,

Stephen L Glasser, OD

Stephen L Glasser, OD, FAAO

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Fiscal Impact Statement

Definition of Optometry Amendment Act of 1997

Bill No. 12-152

Prepared by
the Office of the Chief Financial Officer
May 12, 1997

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OFFICE OF THE CHIEF FINANCIAL OFFICER

OFFICE OF BUDGET AND PLANNING

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1. SPONSOR: Councilmember Cropp

2. BILL NUMBER 12-152

3. TITLE: Definition of Optometry Amendment Act of 1997

4. OVERVIEW:

The proposed legislation amends the District of Columbia Health Occupations Revisions Act of 1985 by redefining the "practice of optometry". The legislation expands the definition of the "eye" and the diagnoses and therapy which can be administered to the eye, including needed surgery, which may be needed for correcting a specific condition. It also requires a certification in order to administer certain therapeutic pharmaceutical agents.

5. FISCAL IMPACT:

The certification of individuals who may use the restricted therapeutic pharmaceutical agents may involve as many as 150 optometrists or it could be that most already have a working arrangement with someone who is qualified and licensed to administer such therapy. In any event, it is not known how many will seek the certification or what the fee for certification will be. At this time, the amount of revenue cannot be quantified. However, it is not expected to be a large amount. The impact of the proposed legislation on the District's Financial Plan and Budget will be minimal.

A possible consideration as to potential savings in the District's Medicaid budget concerns Medicaid eligible patients with severe eye problems, who may see an optometrist prior to his being certified. The uncertified doctor may need to refer the patient to an ophthalmologist who can perform the needed service. This requires Medicaid to pay for two doctors instead of only paying for one. If this legislation is implemented and the uncertified doctor becomes certified, Medicaid may only have to pay for the one office visit, thus generating some potential savings.